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110TH CONGRESS
2D SESSION

H. R. 6331

To amend titles XVIII and XIX of the Social Security Act to extend expiring provisions under the Medicare Program, to improve beneficiary access to preventive and mental health services, to enhance low-income benefit programs, and to maintain access to care in rural areas, including pharmacy access, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 20, 2008

Mr. RANGEL (for himself and Mr. DINGELL) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend titles XVIII and XIX of the Social Security Act to extend expiring provisions under the Medicare Program, to improve beneficiary access to preventive and mental health services, to enhance low-income benefit programs, and to maintain access to care in rural areas, including pharmacy access, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Improvements for Patients and Providers Act of 2008".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE

Subtitle A—Beneficiary Improvements

PART I—PREVENTION, MENTAL HEALTH, AND MARKETING

Sec. 101. Improvements to coverage of preventive services.
Sec. 102. Elimination of discriminatory copayment rates for Medicare outpatient psychiatric services.
Sec. 103. Prohibitions and limitations on certain sales and marketing activities under Medicare Advantage plans and prescription drug plans.
Sec. 104. Improvements to the Medigap program.

PART II—LOW-INCOME PROGRAMS

Sec. 111. Extension of qualifying individual (QI) program.
Sec. 112. Application of full LIS subsidy assets test under Medicare Savings Program.
Sec. 113. Eliminating barriers to enrollment.
Sec. 114. Elimination of Medicare part D late enrollment penalties paid by subsidy eligible individuals.
Sec. 115. Eliminating application of estate recovery.
Sec. 116. Exemptions from income and resources for determination of eligibility for low-income subsidy.
Sec. 117. Judicial review of decisions of the Commissioner of Social Security under the Medicare part D low-income subsidy program.
Sec. 118. Translation of model form.
Sec. 119. Medicare enrollment assistance.

Subtitle B—Provisions Relating to Part A

Sec. 121. Expansion and extension of the Medicare Rural Hospital Flexibility Program.
Sec. 122. Rebasing for sole community hospitals.
Sec. 123. Demonstration project on community health integration models in certain rural counties.
Sec. 124. Extension of the reclassification of certain hospitals.
Sec. 125. Revocation of unique deeming authority of the Joint Commission.

Subtitle C—Provisions Relating to Part B

PART 1—PHYSICIANS' SERVICES

Sec. 131. Physician payment, efficiency, and quality improvements.
Sec. 132. Incentives for electronic prescribing.
Sec. 133. Expanding access to primary care services.
Sec. 134. Extension of floor on Medicare work geographic adjustment under the Medicare physician fee schedule.
Sec. 135. Imaging provisions.
Sec. 136. Extension of treatment of certain physician pathology services under Medicare.
Sec. 137. Accommodation of physicians ordered to active duty in the Armed Services.
Sec. 138. Adjustment for Medicare mental health services.
Sec. 139. Improvements for Medicare anesthesia teaching programs.

PART 2—OTHER PAYMENT AND COVERAGE IMPROVEMENTS

Sec. 141. Extension of exceptions process for Medicare therapy caps.
Sec. 142. Extension of payment rule for brachytherapy and therapeutic radiopharmaceuticals.
Sec. 143. Speech-language pathology services.
Sec. 144. Coverage of pulmonary and cardiac rehabilitation.
Sec. 145. Clinical laboratory tests.
Sec. 146. Improved access to ambulance services.
Sec. 147. Extension and expansion of the Medicare hold harmless provision under the prospective payment system for hospital outpatient department (HOPD) services for certain hospitals.
Sec. 148. Clarification of payment for clinical laboratory tests furnished by critical access hospitals.
Sec. 149. Adding certain entities as originating sites for payment of telehealth services.
Sec. 150. MedPAC study and report on improving chronic care demonstration programs.
Sec. 151. Increase of FQHC payment limits.
Sec. 152. Kidney disease education and awareness provisions.
Sec. 153. Renal dialysis provisions.
Sec. 154. Delay in and reform of Medicare DMEPOS competitive acquisition program.

Subtitle D—Provisions Relating to Part C

Sec. 161. Phase-out of indirect medical education (IME).
Sec. 162. Revisions to requirements for Medicare Advantage private fee-for-service plans.
Sec. 163. Revisions to quality improvement programs.
Sec. 164. Revisions relating to specialized Medicare Advantage plans for special needs individuals.
Sec. 165. Limitation on out-of-pocket costs for dual eligibles and qualified Medicare beneficiaries enrolled in a specialized Medicare Advantage plan for special needs individuals.
Sec. 166. Adjustment to the Medicare Advantage stabilization fund.
Sec. 167. Access to Medicare reasonable cost contract plans.
Sec. 168. MedPAC study and report on quality measures.
Sec. 169. MedPAC study and report on Medicare Advantage payments.

Subtitle E—Provisions Relating to Part D

PART I—IMPROVING PHARMACY ACCESS

Sec. 171. Prompt payment by prescription drug plans and MA–PD plans under part D.
Sec. 172. Regular update of prescription drug pricing standard.

PART II—OTHER PROVISIONS

Sec. 175. Inclusion of barbiturates and benzodiazepines as covered part D drugs.
Sec. 176. Formulary requirements with respect to certain categories or classes of drugs.

Subtitle F—Other Provisions

Sec. 181. Use of part D data.
Sec. 182. Revision of definition of medically accepted indication for drugs.
Sec. 183. Contract with a consensus-based entity regarding performance measurement.
Sec. 184. Cost-sharing for clinical trials.
Sec. 185. Addressing health care disparities.
Sec. 186. Demonstration to improve care to previously uninsured.
Sec. 187. Office of the Inspector General report on compliance with and enforcement of national standards on culturally and linguistically appropriate services (CLAS) in Medicare.
Sec. 188. Medicare Improvement Funding.
Sec. 189. Inclusion of Medicare providers and suppliers in Federal Payment Levy and Administrative Offset Program.

TITLE J—MEDICAID

Sec. 201. Extension of transitional medical assistance (TMA) and abstinence education program.
Sec. 202. Medicaid DSH extension.
Sec. 203. Pharmacy reimbursement under Medicaid.
Sec. 204. Review of administrative claim determinations.
Sec. 205. County Medicaid health insuring organizations.

TITLE K—MISCELLANEOUS

Sec. 301. Extension of TANF supplemental grants.
Sec. 302. 70 percent federal matching for foster care and adoption assistance for the District of Columbia.
Sec. 303. Extension of Special Diabetes Grant Programs.
Sec. 304. IOM reports on best practices for conducting systematic reviews of clinical effectiveness research and for developing clinical protocols.

TITLE I—MEDICARE

Subtitle A—Beneficiary Improvements

PART I—PREVENTION, MENTAL HEALTH, AND MARKETING

SEC. 101. IMPROVEMENTS TO COVERAGE OF PREVENTIVE SERVICES.

(a) COVERAGE OF ADDITIONAL PREVENTIVE SERVICES.—

(1) COVERAGE.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 114 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended—

(A) in subsection (s)(2)—

(i) in subparagraph (Z), by striking "and" after the semicolon at the end;

(ii) in subparagraph (AA), by adding "and" after the semicolon at the end; and

(iii) by adding at the end the following new subparagraph:

"(BB) additional preventive services (described in subsection (ddd)(1));"; and

(B) by adding at the end the following new subsection:

"Additional Preventive Services

"(ddd)(1) The term 'additional preventive services' means services not otherwise described in this title that identify medical conditions or risk factors and that the Secretary determines are—

"(A) reasonable and necessary for the prevention or early detection of an illness or disability;

"(B) recommended with a grade of A or B by the United States Preventive Services Task Force; and

"(C) appropriate for individuals entitled to benefits under part A or enrolled under part B.

"(2) In making determinations under paragraph (1) regarding the coverage of a new service, the Secretary shall use the process for making national coverage determinations (as defined in section 1869(f)(1)(B)) under this title. As part of the use of such process, the Secretary may conduct an assessment of the relation between predicted outcomes and the expenditures for such service and may take into account the results of such assessment in making such determination.".

(2) PAYMENT AND COINSURANCE FOR ADDITIONAL PREVENTIVE SERVICES.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking "and" before "(V)"; and

(B) by inserting before the semicolon at the end the following: ", and (W) with respect to additional preventive services (as defined in section 1861(ddd)(1)), the amount paid shall be (i) in the case of such services which are clinical diagnostic laboratory tests, the amount determined under subparagraph (D), and (ii) in the case of all other such services, 80 percent of the lesser of the actual charge for the service or the amount determined under a fee schedule established by the Secretary for purposes of this subparagraph".

(3) CONFORMING AMENDMENT REGARDING COVERAGE.—Section 1862(a)(1)(A) of the Social Security Act (42 U.S.C. 1395y(a)(1)(A)) is amended by inserting "or additional preventive services (as described in section 1861(ddd)(1))" after "succeeding subparagraph".

(4) RULE OF CONSTRUCTION.—Nothing in the provisions of, or amendments made by, this subsection shall be construed to provide coverage under title XVIII of the Social Security Act of items and services for the treatment of a medical condition that is not otherwise covered under such title.

(b) REVISIONS TO INITIAL PREVENTIVE PHYSICAL EXAMINATION.—

(1) IN GENERAL.—Section 1861(ww) of the Social Security Act (42 U.S.C. 1395x(ww)) is amended—

(A) in paragraph (1)—

(i) by inserting "body mass index," after "weight";

(ii) by striking ", and an electrocardiogram"; and

(iii) by inserting "and end-of-life planning (as defined in paragraph (3)) upon the agreement with the individual" after "paragraph (2)";

(B) in paragraph (2), by adding at the end the following new subparagraphs:

"(M) An electrocardiogram.

"(N) Additional preventive services (as defined in subsection (ddd)(1))."; and

(C) by adding at the end the following new paragraph:

"(3) For purposes of paragraph (1), the term 'end-of-life planning' means verbal or written information regarding—

"(A) an individual's ability to prepare an advance directive in the case that an injury or illness causes the individual to be unable to make health care decisions; and

"(B) whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.".

(2) WAIVER OF APPLICATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(A) by striking "and" before "(8)"; and

(B) by inserting ", and (9) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1861(ww))" before the period at the end.

(3) EXTENSION OF ELIGIBILITY PERIOD FROM SIX MONTHS TO ONE YEAR.—Section 1862(a)(1)(K) of the Social Security Act (42 U.S.C. 1395y(a)(1)(K)) is amended by striking "6 months" and inserting "1 year".

(4) TECHNICAL CORRECTION.—Section 1862(a)(1)(K) of the Social Security Act (42 U.S.C. 1395y(a)(1)(K)) is amended by striking "not later" and inserting "more".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2009.

SEC. 102. ELIMINATION OF DISCRIMINATORY COPAYMENT RATES FOR MEDICARE OUTPATIENT PSYCHIATRIC SERVICES.

Section 1833(c) of the Social Security Act (42 U.S.C. 1395l(c)) is amended to read as follows:

"(c)(1) Notwithstanding any other provision of this part, with respect to expenses incurred in a calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b)—

"(A) for expenses incurred in years prior to 2010, only 62½ percent of such expenses;

"(B) for expenses incurred in 2010 or 2011, only 68¾ percent of such expenses;

"(C) for expenses incurred in 2012, only 75 percent of such expenses;

"(D) for expenses incurred in 2013, only 81¼ percent of such expenses; and

"(E) for expenses incurred in 2014 or any subsequent calendar year, 100 percent of such expenses.

"(2) For purposes of subparagraphs (A) through (D) of paragraph (1), the term 'treatment' does not include brief office visits (as defined by the Secretary) for the sole purpose of monitoring or changing drug prescriptions used in the treatment of such disorders or partial hospitalization services that are not directly provided by a physician.".

SEC. 103. PROHIBITIONS AND LIMITATIONS ON CERTAIN SALES AND MARKETING ACTIVITIES UNDER MEDICARE ADVANTAGE PLANS AND PRESCRIPTION DRUG PLANS.

(a) PROHIBITIONS.—

(1) MEDICARE ADVANTAGE PROGRAM.—

(A) IN GENERAL.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21) is amended—

(i) in subsection (h)(4)—

(I) in subparagraph (A)—

(aa) by striking "cash or other monetary rebates" and inserting ", subject to subsection (j)(2)(C), cash, gifts, prizes, or other monetary rebates"; and

(bb) by striking ", and" at the end and inserting a semicolon;

(II) in subparagraph (B), by striking the period at the end and inserting a semicolon; and

(III) by adding at the end the following new subparagraph:

"(C) shall not permit a Medicare Advantage organization (or the agents, brokers, and other third parties representing such organization) to conduct the prohibited activities described in subsection (j)(1); and"; and

(ii) by adding at the end the following new subsection:

"(j) PROHIBITED ACTIVITIES DESCRIBED AND LIMITATIONS ON THE CONDUCT OF CERTAIN OTHER ACTIVITIES.—

"(1) PROHIBITED ACTIVITIES DESCRIBED.—The following prohibited activities are described in this paragraph:

"(A) UNSOLICITED MEANS OF DIRECT CONTACT.—Any unsolicited means of direct contact of prospective enrollees, including soliciting door-to-door or any outbound tele-

marketing without the prospective enrollee initiating contact.

"(B) CROSS-SELLING.—The sale of other non-health related products (such as annuities and life insurance) during any sales or marketing activity or presentation conducted with respect to a Medicare Advantage plan.

"(C) MEALS.—The provision of meals of any sort, regardless of value, to prospective enrollees at promotional and sales activities.

"(D) SALES AND MARKETING IN HEALTH CARE SETTINGS AND AT EDUCATIONAL EVENTS.—Sales and marketing activities for the enrollment of individuals in Medicare Advantage plans that are conducted—

"(i) in health care settings in areas where health care is delivered to individuals (such as physician offices and pharmacies), except in the case where such activities are conducted in common areas in health care settings; and

"(ii) at educational events.".

(2) MEDICARE PRESCRIPTION DRUG PROGRAM.—Section 1860D–4 of the Social Security Act

(42 U.S.C. 1395w–104) is amended by adding at the end the following new subsection:

"(l) REQUIREMENTS WITH RESPECT TO SALES AND MARKETING ACTIVITIES.—The following provisions shall apply to a PDP sponsor (and the agents, brokers, and other third parties representing such sponsor) in the same manner as such provisions apply to a Medicare Advantage organization (and the agents, brokers, and other third parties representing such organization):

"(1) The prohibition under section 1851(h)(4)(C) on conducting activities described in section 1851(j)(1).".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2009.

(b) LIMITATIONS.—

(1) MEDICARE ADVANTAGE PROGRAM.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21), as amended by subsection (a)(1), is amended—

(A) in subsection (h)(4), by adding at the end the following new subparagraph:

"(D) shall only permit a Medicare Advantage organization (and the agents, brokers, and other third parties representing such organization) to conduct the activities described in sub-

section (j)(2) in accordance with the limitations established under such subsection."; and

(B) in subsection (j), by adding at the end the following new paragraph:

"(2) LIMITATIONS.—The Secretary shall establish limitations with respect to at least the following:

"(A) SCOPE OF MARKETING APPOINTMENTS.—The scope of any appointment with respect to the marketing of a Medicare Advantage plan. Such limitation shall require advance agreement with a prospective enrollee on the scope of the marketing appointment and documentation of such agreement by the Medicare Advantage organization. In the case where the marketing appointment is in person, such documentation shall be in writing.

"(B) CO-BRANDING.—The use of the name or logo of a co-branded network provider on Medicare Advantage plan membership and marketing materials.

"(C) LIMITATION OF GIFTS TO NOMINAL DOLLAR VALUE.—The offering of gifts and other promotional items other than those that are of nominal value (as determined by the Sec-

retary) to prospective enrollees at promotional activities.

"(D) COMPENSATION.—The use of compensation other than as provided under guidelines established by the Secretary. Such guidelines shall ensure that the use of compensation creates incentives for agents and brokers to enroll individuals in the Medicare Advantage plan that is intended to best meet their health care needs.

"(E) REQUIRED TRAINING, ANNUAL RETRAINING, AND TESTING OF AGENTS, BROKERS, AND OTHER THIRD PARTIES.—The use by a Medicare Advantage organization of any individual as an agent, broker, or other third party representing the organization that has not completed an initial training and testing program and does not complete an annual retraining and testing program.".

(2) MEDICARE PRESCRIPTION DRUG PROGRAM.—Section 1860D–4(l) of the Social Security Act, as added by subsection (a)(2), is amended by adding at the end the following new paragraph:

"(2) The requirement under section 1851(h)(4)(D) to conduct activities described in sec-

tion 1851(j)(2) in accordance with the limitations established under such subsection.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on a date specified by the Secretary (but in no case later than November 15, 2008).

(c) REQUIRED INCLUSION OF PLAN TYPE IN PLAN NAME.—

(1) MEDICARE ADVANTAGE PROGRAM.—Section 1851(h) of the Social Security Act (42 U.S.C. 1395w–21(h)) is amended by adding at the end following new paragraph:

"(6) REQUIRED INCLUSION OF PLAN TYPE IN PLAN NAME.—For plan years beginning on or after January 1, 2010, a Medicare Advantage organization must ensure that the name of each Medicare Advantage plan offered by the Medicare Advantage organization includes the plan type of the plan (using standard terminology developed by the Secretary).".

(2) PRESCRIPTION DRUG PLANS.—Section 1860D–4(l) of the Social Security Act, as added by subsection (a)(2) and amended by subsection (b)(2), is amended by adding at the end the following new paragraph:

"(3) The inclusion of the plan type in the plan name under section 1851(h)(6).".

(d) STRENGTHENING THE ABILITY OF STATES TO ACT IN COLLABORATION WITH THE SECRETARY TO ADDRESS FRAUDULENT OR INAPPROPRIATE MARKETING PRACTICES.—

(1) MEDICARE ADVANTAGE PROGRAM.—Section 1851(h) of the Social Security Act (42 U.S.C. 1395w–21(h), as amended by subsection (c)(1), is amended by adding at the end the following new paragraph:

"(7) STRENGTHENING THE ABILITY OF STATES TO ACT IN COLLABORATION WITH THE SECRETARY TO ADDRESS FRAUDULENT OR INAPPROPRIATE MARKETING PRACTICES.—

"(A) APPOINTMENT OF AGENTS AND BROKERS.—Each Medicare Advantage organization shall—

"(i) only use agents and brokers who have been licensed under State law to sell Medicare Advantage plans offered by the Medicare Advantage organization;

"(ii) in the case where a State has a State appointment law, abide by such law; and

"(iii) report to the applicable State the termination of any such agent or broker, including the reasons for such termination (as required under applicable State law).

"(B) COMPLIANCE WITH STATE INFORMATION REQUESTS.—Each Medicare Advantage organization shall comply in a timely manner with any request by a State for information regarding the performance of a licensed agent, broker, or other third party representing the Medicare Advantage organization as part of an investigation by the State into the conduct of the agent, broker, or other third party.".

(2) PRESCRIPTION DRUG PLANS.—Section 1860D–4(l) of the Social Security Act, as amended by subsection (c)(2), is amended by adding at the end the following new paragraph:

"(4) The requirements regarding the appointment of agents and brokers and compliance with State information requests under subparagraphs (A) and (B), respectively, of section 1851(h)(7).".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2009.

SEC. 104. IMPROVEMENTS TO THE MEDIGAP PROGRAM.

(a) IMPLEMENTATION OF NAIC RECOMMENDATIONS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall provide for implementation of the changes in the NAIC model law and regulations approved by the National Association of Insurance Commissioners in its Model #651 ("Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act") on March 11, 2007, as modified to reflect the changes made under this Act and the Genetic Information Nondiscrimination Act of 2008 (Public Law 110–233).

(2) IMPLEMENTATION DATES.—

(A) IN GENERAL.—The modifications to Model #651 required under paragraph (1) shall be completed by the National Association of Insurance Commissioners not later than October 31, 2008. Except as provided in subparagraph (B), each State shall have 1 year from the date the National Association of Insurance Commissioners adopts the revised NAIC model law and regulations (as changed by Model #651, as so modified) to conform the regulatory program

established by the State to such revised NAIC model law and regulations.

(B) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State which the Secretary determines requires State legislation in order to conform the regulatory program established by the State to such revised NAIC model law and regulations, the State shall not be regarded as failing to comply with the requirements of this section solely on the basis of its failure to meet such requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

(C) TRANSITION DATES.—No carrier may issue a new or revised Medicare supplemental policy or certificate under section 1882 of the Social Security Act (42 U.S.C. 1395ss) that meets the requirements of such revised NAIC

model law and regulations for coverage effective prior to June 1, 2010. A carrier may continue to offer or issue a Medicare supplemental policy under such section that meets the requirements of the NAIC model law and regulations and State law (as in effect prior to the adoption of such revised NAIC model law and regulations) prior to June 1, 2010. Nothing shall preclude carriers from marketing new or revised Medicare supplemental policies or certificates that meet the requirements of such revised NAIC model law and regulations on or after the date on which the State conforms the regulatory program established by the State to such revised NAIC model law and regulations.

(b) REQUIRED OFFERING OF A RANGE OF POLICIES.—Section 1882(o) of the Social Security Act (42 U.S.C. 1395s(o)), as amended by section 104(b)(3) of the Genetic Information Nondiscrimination Act of 2008 (Public Law 110–233), is amended by adding at the end the following new paragraph:

"(5) In addition to the requirement under paragraph (2), the issuer of the policy must make available to the individual at least Medicare supplemental

policies with benefit packages classified as 'C' or 'F'.".

(c) CLARIFICATION.—Any health insurance policy that provides reimbursement for expenses incurred for items and services for which payment may be made under title XVIII of the Social Security Act but which are not reimbursable by reason of the applicability of deductibles, coinsurance, copayments or other limitations imposed by a Medicare Advantage plan (including a Medicare Advantage private fee-for-service plan) under part C of such title shall comply with the requirements of section 1882(o) of the such Act (42 U.S.C. 1395ss(o)).

PART II—LOW-INCOME PROGRAMS

SEC. 111. EXTENSION OF QUALIFYING INDIVIDUAL (QI) PROGRAM.

(a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking "June 2008" and inserting "December 2009".

(b) EXTENDING TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(g) of such Act (42 U.S.C. 1396u–3(g)) is amended—

(1) in paragraph (2)—

(A) by striking "and" at the end of subparagraph (H);

(B) in subparagraph (I)—

(i) by striking "June 30" and inserting "September 30";

(ii) by striking "$200,000,000" and inserting "$300,000,000"; and

(iii) by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following new subparagraphs:

"(J) for the period that begins on October 1, 2008, and ends on December 31, 2008, the total allocation amount is $100,000,000;

"(K) for the period that begins on January 1, 2009, and ends on September 30, 2009, the total allocation amount is $350,000,000; and

"(L) for the period that begins on October 1, 2009, and ends on December 31, 2009, the total allocation amount is $150,000,000."; and

(2) in paragraph (3), in the matter preceding subparagraph (A), by striking "or (H)" and inserting "(H), (J), or (L)".

SEC. 112. APPLICATION OF FULL LIS SUBSIDY ASSETS TEST UNDER MEDICARE SAVINGS PROGRAM.

Section 1905(p)(1)(C) of such Act (42 U.S.C. 1396d(p)(1)(C)) is amended by inserting before the period

at the end the following: "or, effective beginning with January 1, 2010, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1860D–14(a)(3) (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be)".

SEC. 113. ELIMINATING BARRIERS TO ENROLLMENT.

(a) SSA ASSISTANCE WITH MEDICARE SAVINGS PROGRAM AND LOW-INCOME SUBSIDY PROGRAM APPLICATIONS.—Section 1144 of such Act (42 U.S.C. 1320b–14) is amended by adding at the end the following new subsection:

"(c) ASSISTANCE WITH MEDICARE SAVINGS PROGRAM AND LOW-INCOME SUBSIDY PROGRAM APPLICATIONS.—

"(1) DISTRIBUTION OF APPLICATIONS AND INFORMATION TO INDIVIDUALS WHO ARE POTENTIALLY ELIGIBLE FOR LOW-INCOME SUBSIDY PROGRAM.—For each individual who submits an application for low-income subsidies under section 1860D–14, requests an application for such subsidies, or is otherwise identified as an individual who is poten-

tially eligible for such subsidies, the Commissioner shall do the following:

"(A) Provide information describing the low-income subsidy program under section 1860D–14 and the Medicare Savings Program (as defined in paragraph (7)).

"(B) Provide an application for enrollment under such low-income subsidy program (if not already received by the Commissioner).

"(C) In accordance with paragraph (3), transmit data from such an application for purposes of initiating an application for benefits under the Medicare Savings Program.

"(D) Provide information on how the individual may obtain assistance in completing such application and an application under the Medicare Savings Program, including information on how the individual may contact the State health insurance assistance program (SHIP).

"(E) Make the application described in subparagraph (B) and the information described in subparagraphs (A) and (D) available at local offices of the Social Security Administration.

"(2) TRAINING PERSONNEL IN EXPLAINING BENEFIT PROGRAMS AND ASSISTING IN COMPLETING LIS APPLICATION.—The Commissioner shall provide training to those employees of the Social Security Administration who are involved in receiving applications for benefits described in paragraph (1)(B) in order that they may promote beneficiary understanding of the low-income subsidy program and the Medicare Savings Program in order to increase participation in these programs. Such employees shall provide assistance in completing an application described in paragraph (1)(B) upon request.

"(3) TRANSMITTAL OF DATA TO STATES.—Beginning on January 1, 2010, with the consent of an individual completing an application for benefits described in paragraph (1)(B), the Commissioner shall electronically transmit to the appropriate State Medicaid agency data from such application, as determined by the Commissioner, which transmittal shall initiate an application of the individual for benefits under the Medicare Savings Program with the State Medicaid agency. In order to ensure that such data transmittal provides effective assistance for purposes of State adjudication of applications for benefits under the Medicare Savings Program, the Commis-

sioner shall consult with the Secretary, after the Secretary has consulted with the States, regarding the content, form, frequency, and manner in which data (on a uniform basis for all States) shall be transmitted under this subparagraph.

"(4) COORDINATION WITH OUTREACH.—The Commissioner shall coordinate outreach activities under this subsection in connection with the low-income subsidy program and the Medicare Savings Program.

"(5) REIMBURSEMENT OF SOCIAL SECURITY ADMINISTRATION ADMINISTRATIVE COSTS.—

"(A) INITIAL MEDICARE SAVINGS PROGRAM COSTS; ADDITIONAL LOW-INCOME SUBSIDY COSTS.—

"(i) INITIAL MEDICARE SAVINGS PROGRAM COSTS.—There are hereby appropriated to the Commissioner to carry out this subsection, out of any funds in the Treasury not otherwise appropriated, $24,100,000. The amount appropriated under ths clause shall be available on October 1, 2008, and shall remain available until expended.

"(ii) ADDITIONAL AMOUNT FOR LOW-INCOME SUBSIDY ACTIVITIES.—There are hereby appropriated to the Commissioner, out of any funds in the Treasury not otherwise appropriated, $24,800,000 for fiscal year 2009 to carry out low-income subsidy activities under section 1860D–14 and the Medicare Savings Program (in accordance with this subsection), to remain available until expended. Such funds shall be in addition to the Social Security Administration's Limitation on Administrative Expenditure appropriations for such fiscal year.

"(B) SUBSEQUENT FUNDING UNDER AGREEMENTS.—

"(i) IN GENERAL.—Effective for fiscal years beginning on or after October 1, 2010, the Commissioner and the Secretary shall enter into an agreement which shall provide funding to cover the administrative costs of the Commissioner's activities under this subsection. Such agreement shall—

"(I) provide funds to the Commissioner for the full cost of the Social Security Administration's work related to the Medicare Savings Program required under this section;

"(II) provide such funding quarterly in advance of the applicable quarter based on estimating methodology agreed to by the Commissioner and the Secretary; and

"(III) require an annual accounting and reconciliation of the actual costs incurred and funds provided under this subsection.

"(ii) APPROPRIATION.—There are hereby appropriated to the Secretary solely for the purpose of providing payments to the Commissioner pursuant to an agreement specified in clause (i) that is in effect, out of any funds in the Treasury not otherwise appropriated, not more than $3,000,000 for fiscal year 2011 and each fiscal year thereafter.

"(C) LIMITATION.—In no case shall funds from the Social Security Administration's Limi-

tation on Administrative Expenses be used to carry out activities related to the Medicare Savings Program. For fiscal years beginning on or after October 1, 2010, no such activities shall be undertaken by the Social Security Administration unless the agreement specified in subparagraph (B) is in effect and full funding has been provided to the Commissioner as specified in such subparagraph.

"(6) GAO ANALYSIS AND REPORT.—

"(A) ANALYSIS.—The Comptroller General of the United States shall prepare an analysis of the impact of this subsection—

"(i) in increasing participation in the Medicare Savings Program, and

"(ii) on States and the Social Security Administration.

"(B) REPORT.—Not later than January 1, 2012, the Comptroller General shall submit to Congress, the Commissioner, and the Secretary a report on the analysis conducted under subparagraph (A).

"(7) MEDICARE SAVINGS PROGRAM DEFINED.—For purposes of this subsection, the term 'Medicare Savings Program' means the program of medical as-

sistance for payment of the cost of Medicare cost-sharing under the Medicaid program pursuant to sections 1902(a)(10)(E) and 1933.".

(b) MEDICAID AGENCY CONSIDERATION OF DATA TRANSMITTAL.—

(1) IN GENERAL.—Section 1935(a) of such Act (42 U.S.C. 1396u–5(a)) is amended by adding at the end the following new paragraph:

"(4) CONSIDERATION OF DATA TRANSMITTED BY THE SOCIAL SECURITY ADMINISTRATION FOR PURPOSES OF MEDICARE SAVINGS PROGRAM.—The State shall accept data transmitted under section 1144(c)(3) and act on such data in the same manner and in accordance with the same deadlines as if the data constituted an initiation of an application for benefits under the Medicare Savings Program (as defined for purposes of such section) that had been submitted directly by the applicant. The date of the individual's application for the low income subsidy program from which the data have been derived shall constitute the date of filing of such application for benefits under the Medicare Savings Program.".

(2) CONFORMING AMENDMENTS.—Section 1935(a) of such Act (42 U.S.C. 1396u–5(a)) is

amended in the subsection heading by striking "AND" and by inserting ", AND MEDICARE COST-SHARING" after "ASSISTANCE".

(c) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall take effect on January 1, 2010.

SEC. 114. ELIMINATION OF MEDICARE PART D LATE ENROLLMENT PENALTIES PAID BY SUBSIDY ELIGIBLE INDIVIDUALS.

(a) WAIVER OF LATE ENROLLMENT PENALTY.—

(1) IN GENERAL.—Section 1860D–13(b) of the Social Security Act (42 U.S.C. 1395w–113(b)) is amended by adding at the end the following new paragraph:

"(8) WAIVER OF PENALTY FOR SUBSIDY-ELIGIBLE INDIVIDUALS.—In no case shall a part D eligible individual who is determined to be a subsidy eligible individual (as defined in section 1860D–14(a)(3)) be subject to an increase in the monthly beneficiary premium established under subsection (a).".

(2) CONFORMING AMENDMENT.—Section 1860D–14(a)(1)(A) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(A)) is amended by striking "equal to" and all that follows through the period

and inserting "equal to 100 percent of the amount described in subsection (b)(1), but not to exceed the premium amount specified in subsection (b)(2)(B).".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to subsidies for months beginning with January 2009.

SEC. 115. ELIMINATING APPLICATION OF ESTATE RECOVERY.

(a) IN GENERAL.—Section 1917(b)(1)(B)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(B)(ii)) is amended by inserting "(but not including medical assistance for Medicare cost-sharing or for benefits described in section 1902(a)(10)(E))" before the period at the end.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as of January 1, 2010.

SEC. 116. EXEMPTIONS FROM INCOME AND RESOURCES FOR DETERMINATION OF ELIGIBILITY FOR LOW-INCOME SUBSIDY.

(a) IN GENERAL.—Section 1860D–14(a)(3) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)) is amended—

(1) in subparagraph (C)(i), by inserting "and except that support and maintenance furnished in kind shall not be counted as income" after "section 1902(r)(2)";

(2) in subparagraph (D), in the matter before clause (i), by inserting "subject to the life insurance policy exclusion provided under subparagraph (G)" before ")";

(3) in subparagraph (E)(i), in the matter before subclause (I), by inserting "subject to the life insurance policy exclusion provided under subparagraph (G)" before ")"; and

(4) by adding at the end the following new subparagraph:

"(G) LIFE INSURANCE POLICY EXCLUSION.—In determining the resources of an individual (and the eligible spouse of the individual, if any) under section 1613 for purposes of subparagraphs (D) and (E) no part of the value of any life insurance policy shall be taken into account.".

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect with respect to applications filed on or after January 1, 2010.

SEC. 117. JUDICIAL REVIEW OF DECISIONS OF THE COMMISSIONER OF SOCIAL SECURITY UNDER THE MEDICARE PART D LOW-INCOME SUBSIDY PROGRAM.

(a) IN GENERAL.—Section 1860D–14(a)(3)(B)(iv) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(B)(iv)) is amended—

(1) in subclause (I), by striking "and" at the end;

(2) in subclause (II), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subclause:

"(III) judicial review of the final decision of the Commissioner made after a hearing shall be available to the same extent, and with the same limitations, as provided in subsections (g) and (h) of section 205.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

SEC. 118. TRANSLATION OF MODEL FORM.

(a) IN GENERAL.—Section 1905(p)(5)(A) of the Social Security Act (42 U.S.C. 1396d(p)(5)(A)) is amended

by adding at the end the following: "The Secretary shall provide for the translation of such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under section 226 or 226A and shall make the translated forms available to the States and to the Commissioner of Social Security.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2010.

SEC. 119. MEDICARE ENROLLMENT ASSISTANCE.

(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE ASSISTANCE PROGRAMS.—

(1) GRANTS.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall use amounts made available under subparagraph (B) to make grants to States for State health insurance assistance programs receiving assistance under section 4360 of the Omnibus Budget Reconciliation Act of 1990.

(B) FUNDING.—For purposes of making grants under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section

1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–23(f)), of $7,500,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2009, to remain available until expended.

(2) AMOUNT OF GRANTS.—The amount of a grant to a State under this subsection from the total amount made available under paragraph (1) shall be equal to the sum of the amount allocated to the State under paragraph (3)(A) and the amount allocated to the State under subparagraph (3)(B).

(3) ALLOCATION TO STATES.—

(A) ALLOCATION BASED ON PERCENTAGE OF LOW-INCOME BENEFICIARIES.—The amount allocated to a State under this subparagraph from ⅔ of the total amount made available under paragraph (1) shall be based on the number of individuals who meet the requirement under subsection (a)(3)(A)(ii) of section 1860D–14 of the Social Security Act (42

U.S.C. 1395w–114) but who have not enrolled to receive a subsidy under such section 1860D–14 relative to the total number of individuals who meet the requirement under such subsection (a)(3)(A)(ii) in each State, as estimated by the Secretary.

(B) ALLOCATION BASED ON PERCENTAGE OF RURAL BENEFICIARIES.—The amount allocated to a State under this subparagraph from ⅓ of the total amount made available under paragraph (1) shall be based on the number of part D eligible individuals (as defined in section 1860D–1(a)(3)(A) of such Act (42 U.S.C. 1395w–101(a)(3)(A))) residing in a rural area relative to the total number of such individuals in each State, as estimated by the Secretary.

(4) PORTION OF GRANT BASED ON PERCENTAGE OF LOW-INCOME BENEFICIARIES TO BE USED TO PROVIDE OUTREACH TO INDIVIDUALS WHO MAY BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGIBLE FOR THE MEDICARE SAVINGS PROGRAM.—Each grant awarded under this subsection with respect to amounts allocated under paragraph (3)(A) shall be used to provide outreach to individuals who may be subsidy eligible individuals (as defined in section

1860D–14(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(A)) or eligible for the Medicare Savings Program (as defined in subsection (f)).

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—

(1) GRANTS.—

(A) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Aging, shall make grants to States for area agencies on aging (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)) and Native American programs carried out under the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.).

(B) FUNDING.—For purposes of making grants under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–

23(f)), of $7,500,000 to the Administration on Aging for fiscal year 2009, to remain available until expended.

(2) AMOUNT OF GRANT AND ALLOCATION TO STATES BASED ON PERCENTAGE OF LOW-INCOME AND RURAL BENEFICIARIES.—The amount of a grant to a State under this subsection from the total amount made available under paragraph (1) shall be determined in the same manner as the amount of a grant to a State under subsection (a), from the total amount made available under paragraph (1) of such subsection, is determined under paragraph (2) and subparagraphs (A) and (B) of paragraph (3) of such subsection.

(3) REQUIRED USE OF FUNDS.—

(A) ALL FUNDS.—Subject to subparagraph (B), each grant awarded under this subsection shall be used to provide outreach to eligible Medicare beneficiaries regarding the benefits available under title XVIII of the Social Security Act.

(B) OUTREACH TO INDIVIDUALS WHO MAY BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGIBLE FOR THE MEDICARE SAVINGS PROGRAM.—Subsection (a)(4) shall apply to each grant

awarded under this subsection in the same manner as it applies to a grant under subsection (a).

(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—

(1) GRANTS.—

(A) IN GENERAL.—The Secretary shall make grants to Aging and Disability Resource Centers under the Aging and Disability Resource Center grant program that are established centers under such program on the date of the enactment of this Act.

(B) FUNDING.—For purposes of making grants under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–23(f)), of $5,000,000 to the Administration on Aging for fiscal year 2009, to remain available until expended.

(2) REQUIRED USE OF FUNDS.—Each grant awarded under this subsection shall be used to provide outreach to individuals regarding the benefits available under the Medicare prescription drug benefit under part D of title XVIII of the Social Security Act and under the Medicare Savings Program.

(d) COORDINATION OF EFFORTS TO INFORM OLDER AMERICANS ABOUT BENEFITS AVAILABLE UNDER FEDERAL AND STATE PROGRAMS.—

(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Aging, in cooperation with related Federal agency partners, shall make a grant to, or enter into a contract with, a qualified, experienced entity under which the entity shall—

(A) maintain and update web-based decision support tools, and integrated, person-centered systems, designed to inform older individuals (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)) about the full range of benefits for which the individuals may be eligible under Federal and State programs;

(B) utilize cost-effective strategies to find older individuals with the greatest economic

need (as defined in such section 102) and inform the individuals of the programs;

(C) develop and maintain an information clearinghouse on best practices and the most cost-effective methods for finding older individuals with greatest economic need and informing the individuals of the programs; and

(D) provide, in collaboration with related Federal agency partners administering the Federal programs, training and technical assistance on the most effective outreach, screening, and follow-up strategies for the Federal and State programs.

(2) FUNDING.—For purposes of making a grant or entering into a contract under paragraph (1), the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–23(f)), of $5,000,000 to the Administration on Aging for fiscal year 2009, to remain available until expended.

(e) REPROGRAMMING FUNDS FROM MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT OF 2007.—The Secretary shall only use the $5,000,000 in funds allocated to make grants to States for Area Agencies on Aging and Aging Disability and Resource Centers for the period of fiscal years 2008 through 2009 under section 118 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) for the sole purpose of providing outreach to individuals regarding the benefits available under the Medicare prescription drug benefit under part D of title XVIII of the Social Security Act. The Secretary shall republish the request for proposals issued on April 17, 2008, in order to comply with the preceding sentence.

(f) MEDICARE SAVINGS PROGRAM DEFINED.—For purposes of this section, the term "Medicare Savings Program" means the program of medical assistance for payment of the cost of Medicare cost-sharing under the Medicaid program pursuant to sections 1902(a)(10)(E) and 1933 of the Social Security Act (42 U.S.C. 1396a(a)(10)(E), 1396u–3).

Subtitle B—Provisions Relating to Part A

SEC. 121. EXPANSION AND EXTENSION OF THE MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) IN GENERAL.—Section 1820(g) of the Social Security Act (42 U.S.C. 1395i–4(g)) is amended by adding at the end the following new paragraph:

"(6) PROVIDING MENTAL HEALTH SERVICES AND OTHER HEALTH SERVICES TO VETERANS AND OTHER RESIDENTS OF RURAL AREAS.—

"(A) GRANTS TO STATES.—The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for increasing the delivery of mental health services or other health care services deemed necessary to meet the needs of veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in rural areas (as defined for purposes of section 1886(d) and including areas that are rural census tracks, as defined by the Administrator of the Health Resources and Services Administration), including for the provision of crisis intervention services and the detection of post-traumatic stress disorder, traumatic brain injury, and other signa-

ture injuries of veterans of Operation Iraqi Freedom and Operation Enduring Freedom, and for referral of such veterans to medical facilities operated by the Department of Veterans Affairs, and for the delivery of such services to other residents of such rural areas.

"(B) APPLICATION.—

"(i) IN GENERAL.—An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii) and (A)(iii) of subsection (b)(1).

"(ii) CONSIDERATION OF REGIONAL APPROACHES, NETWORKS, OR TECHNOLOGY.—The Secretary may, as appropriate in awarding grants to States under subparagraph (A), consider whether the application submitted by a State under this subparagraph includes 1 or more proposals that utilize regional approaches, networks, health information technology, telehealth, or telemedicine to deliver services described in subparagraph (A) to indi-

viduals described in that subparagraph. For purposes of this clause, a network may, as the Secretary determines appropriate, include federally qualified health centers (as defined in section 1861(aa)(4)), rural health clinics (as defined in section 1861(aa)(2)), home health agencies (as defined in section 1861(o)), community mental health centers (as defined in section 1861(ff)(3)(B)) and other providers of mental health services, pharmacists, local government, and other providers deemed necessary to meet the needs of veterans.

"(iii) COORDINATION AT LOCAL LEVEL.—The Secretary shall require, as appropriate, a State to demonstrate consultation with the hospital association of such State, rural hospitals located in such State, providers of mental health services, or other appropriate stakeholders for the provision of services under a grant awarded under this paragraph.

"(iv) SPECIAL CONSIDERATION OF CERTAIN APPLICATIONS.—In awarding grants to States under subparagraph (A),

the Secretary shall give special consideration to applications submitted by States in which veterans make up a high percentage (as determined by the Secretary) of the total population of the State. Such consideration shall be given without regard to the number of veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in the areas in which mental health services and other health care services would be delivered under the application.

"(C) COORDINATION WITH VA.—The Secretary shall, as appropriate, consult with the Director of the Office of Rural Health of the Department of Veterans Affairs in awarding and administering grants to States under subparagraph (A).

"(D) USE OF FUNDS.—A State awarded a grant under this paragraph may, as appropriate, use the funds to reimburse providers of services described in subparagraph (A) to individuals described in that subparagraph.

"(E) LIMITATION ON USE OF GRANT FUNDS FOR ADMINISTRATIVE EXPENSES.—A

State awarded a grant under this paragraph may not expend more than 15 percent of the amount of the grant for administrative expenses.

"(F) INDEPENDENT EVALUATION AND FINAL REPORT.—The Secretary shall provide for an independent evaluation of the grants awarded under subparagraph (A). Not later than 1 year after the date on which the last grant is awarded to a State under such subparagraph, the Secretary shall submit a report to Congress on such evaluation. Such report shall include an assessment of the impact of such grants on increasing the delivery of mental health services and other health services to veterans of the United States Armed Forces living in rural areas (as so defined and including such areas that are rural census tracks), with particular emphasis on the impact of such grants on the delivery of such services to veterans of Operation Enduring Freedom and Operation Iraqi Freedom, and to other individuals living in such rural areas.".

(b) USE OF FUNDS FOR FEDERAL ADMINISTRATIVE EXPENSES.—Section 1820(g)(5) of the Social Security Act (42 U.S.C. 1395i–4(g)(5)) is amended—

(1) by striking "beginning with fiscal year 2005" and inserting "for each of fiscal years 2005 through 2008"; and

(2) by inserting "and, of the total amount appropriated for grants under paragraphs (1), (2), and (6) for a fiscal year (beginning with fiscal year 2009)" after "2005)".

(c) EXTENSION OF AUTHORIZATION FOR FLEX GRANTS.—Section 1820(j) of the Social Security Act (42 U.S.C. 1395i–4(j)) is amended—

(1) by striking "and for" and inserting "for"; and

(2) by inserting ", for making grants to all States under paragraphs (1) and (2) of subsection (g), $55,000,000 in each of fiscal years 2009 and 2010, and for making grants to all States under paragraph (6) of subsection (g), $50,000,000 in each of fiscal years 2009 and 2010, to remain available until expended" before the period at the end.

(d) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—Section 1820(g)(1) of the Social Security Act (42 U.S.C. 1395i–4(g)(1)) is amended—

(1) in subparagraph (B), by striking "and" at the end;

(2) in subparagraph (C), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(D) providing support for critical access hospitals for quality improvement, quality reporting, performance improvements, and benchmarking.".

(e) ASSISTANCE TO SMALL CRITICAL ACCESS HOSPITALS TRANSITIONING TO SKILLED NURSING FACILITIES AND ASSISTED LIVING FACILITIES.—Section 1820(g) of the Social Security Act (42 U.S.C. 1395i–4(g)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

"(7) CRITICAL ACCESS HOSPITALS TRANSITIONING TO SKILLED NURSING FACILITIES AND ASSISTED LIVING FACILITIES.—

"(A) GRANTS.—The Secretary may award grants to eligible critical access hospitals that have submitted applications in accordance with subparagraph (B) for assisting such hospitals in the transition to skilled nursing facilities and assisted living facilities.

"(B) APPLICATION.—An applicable critical access hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

"(C) ADDITIONAL REQUIREMENTS.—The Secretary may not award a grant under this paragraph to an eligible critical access hospital unless—

"(i) local organizations or the State in which the hospital is located provides matching funds; and

"(ii) the hospital provides assurances that it will surrender critical access hospital status under this title within 180 days of receiving the grant.

"(D) AMOUNT OF GRANT.—A grant to an eligible critical access hospital under this paragraph may not exceed $1,000,000.

"(E) FUNDING.—There are appropriated from the Federal Hospital Insurance Trust Fund under section 1817 for making grants under this paragraph, $5,000,000 for fiscal year 2008.

"(F) ELIGIBLE CRITICAL ACCESS HOSPITAL DEFINED.—For purposes of this paragraph, the term 'eligible critical access hospital' means a critical access hospital that has an average daily acute census of less than 0.5 and an average daily swing bed census of greater than 10.0.".

SEC. 122. REBASING FOR SOLE COMMUNITY HOSPITALS.

(a) REBASING PERMITTED.—Section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)) is amended by adding at the end the following new subparagraph:

"(L)(i) For cost reporting periods beginning on or after January 1, 2009, in the case of a sole community hospital there shall be substituted for the amount otherwise determined under subsection (d)(5)(D)(i) of this section, if such substitution results in a greater amount of payment under this section for the hospital, the subparagraph (L) rebased target amount.

"(ii) For purposes of this subparagraph, the term 'subparagraph (L) rebased target amount' has the meaning given the term 'target amount' in subparagraph (C), except that—

"(I) there shall be substituted for the base cost reporting period the 12-month cost reporting period beginning during fiscal year 2006;

"(II) any reference in subparagraph (C)(i) to the 'first cost reporting period' described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after January 1, 2009; and

"(III) the applicable percentage increase shall only be applied under subparagraph (C)(iv) for discharges occurring on or after January 1, 2009.".

(b) CONFORMING AMENDMENTS.—Section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)) is amended—

(1) in subparagraph (C), in the matter preceding clause (i), by striking "subparagraph (I)" and inserting "subparagraphs (I) and (L)"; and

(2) in subparagraph (I)(i), in the matter preceding subclause (I), by striking "For" and inserting "Subject to subparagraph (L), for".

SEC. 123. DEMONSTRATION PROJECT ON COMMUNITY HEALTH INTEGRATION MODELS IN CERTAIN RURAL COUNTIES.

(a) IN GENERAL.—The Secretary shall establish a demonstration project to allow eligible entities to develop

and test new models for the delivery of health care services in eligible counties for the purpose of improving access to, and better integrating the delivery of, acute care, extended care, and other essential health care services to Medicare beneficiaries.

(b) PURPOSE.—The purpose of the demonstration project under this section is to—

(1) explore ways to increase access to, and improve the adequacy of, payments for acute care, extended care, and other essential health care services provided under the Medicare and Medicaid programs in eligible counties; and

(2) evaluate regulatory challenges facing such providers and the communities they serve.

(c) REQUIREMENTS.—The following requirements shall apply under the demonstration project:

(1) Health care providers in eligible counties selected to participate in the demonstration project under subsection (d)(3) shall (when determined appropriate by the Secretary), instead of the payment rates otherwise applicable under the Medicare program, be reimbursed at a rate that covers at least the reasonable costs of the provider in furnishing acute care, extended care, and other essential health care services to Medicare beneficiaries.

(2) Methods to coordinate the survey and certification process under the Medicare program and the Medicaid program across all health service categories included in the demonstration project shall be tested with the goal of assuring quality and safety while reducing administrative burdens, as appropriate, related to completing such survey and certification process.

(3) Health care providers in eligible counties selected to participate in the demonstration project under subsection (d)(3) and the Secretary shall work with the State to explore ways to revise reimbursement policies under the Medicaid program to improve access to the range of health care services available in such eligible counties.

(4) The Secretary shall identify regulatory requirements that may be revised appropriately to improve access to care in eligible counties.

(5) Other essential health care services necessary to ensure access to the range of health care services in eligible counties selected to participate in the demonstration project under subsection (d)(3) shall be identified. Ways to ensure adequate funding for such services shall also be explored.

(d) APPLICATION PROCESS.—

(1) ELIGIBILITY.—

(A) IN GENERAL.—Eligibility to participate in the demonstration project under this section shall be limited to eligible entities.

(B) ELIGIBLE ENTITY DEFINED.—In this section, the term "eligible entity" means an entity that—

(i) is a Rural Hospital Flexibility Program grantee under section 1820(g) of the Social Security Act (42 U.S.C. 1395i–4(g)); and

(ii) is located in a State in which at least 65 percent of the counties in the State are counties that have 6 or less residents per square mile.

(2) APPLICATION.—

(A) IN GENERAL.—An eligible entity seeking to participate in the demonstration project under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(B) LIMITATION.—The Secretary shall select eligible entities located in not more than 4

States to participate in the demonstration project under this section.

(3) SELECTION OF ELIGIBLE COUNTIES.—An eligible entity selected by the Secretary to participate in the demonstration project under this section shall select not more than 6 eligible counties in the State in which the entity is located in which to conduct the demonstration project.

(4) ELIGIBLE COUNTY DEFINED.—In this section, the term "eligible county" means a county that meets the following requirements:

(A) The county has 6 or less residents per square mile.

(B) As of the date of the enactment of this Act, a facility designated as a critical access hospital which meets the following requirements was located in the county:

(i) As of the date of the enactment of this Act, the critical access hospital furnished 1 or more of the following:

(I) Home health services.

(II) Hospice care.

(III) Rural health clinic services.

(ii) As of the date of the enactment of this Act, the critical access hospital has an average daily inpatient census of 5 or less.

(C) As of the date of the enactment of this Act, skilled nursing facility services were available in the county in—

(i) a critical access hospital using swing beds; or

(ii) a local nursing home.

(e) ADMINISTRATION.—

(1) IN GENERAL.—The demonstration project under this section shall be administered jointly by the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration and the Administrator of the Centers for Medicare & Medicaid Services, in accordance with paragraphs (2) and (3).

(2) HRSA DUTIES.—In administering the demonstration project under this section, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration shall—

(A) award grants to the eligible entities selected to participate in the demonstration project; and

(B) work with such entities to provide technical assistance related to the requirements under the project.

(3) CMS DUTIES.—In administering the demonstration project under this section, the Administrator of the Centers for Medicare & Medicaid Services shall determine which provisions of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) the Secretary should waive under the waiver authority under subsection (i) that are relevant to the development of alternative reimbursement methodologies, which may include, as appropriate, covering at least the reasonable costs of the provider in furnishing acute care, extended care, and other essential health care services to Medicare beneficiaries and coordinating the survey and certification process under the Medicare and Medicaid programs, as appropriate, across all service categories included in the demonstration project.

(f) DURATION.—

(1) IN GENERAL.—The demonstration project under this section shall be conducted for a 3-year period beginning on October 1, 2009.

(2) BEGINNING DATE OF DEMONSTRATION PROJECT.—The demonstration project under this

section shall be considered to have begun in a State on the date on which the eligible counties selected to participate in the demonstration project under subsection (d)(3) begin operations in accordance with the requirements under the demonstration project.

(g) FUNDING.—

(1) CMS.—

(A) IN GENERAL.—The Secretary shall provide for the transfer, in appropriate part from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), of such sums as are necessary for the costs to the Centers for Medicare & Medicaid Services of carrying out its duties under the demonstration project under this section.

(B) BUDGET NEUTRALITY.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary estimates

would have been paid if the demonstration project under this section was not implemented.

(2) HRSA.—There are authorized to be appropriated to the Office of Rural Health Policy of the Health Resources and Services Administration $800,000 for each of fiscal years 2010, 2011, and 2012 for the purpose of carrying out the duties of such Office under the demonstration project under this section, to remain available for the duration of the demonstration project.

(h) REPORT.—

(1) INTERIM REPORT.—Not later than the date that is 2 years after the date on which the demonstration project under this section is implemented, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration, in coordination with the Administrator of the Centers for Medicare & Medicaid Services, shall submit a report to Congress on the status of the demonstration project that includes initial recommendations on ways to improve access to, and the availability of, health care services in eligible counties based on the findings of the demonstration project.

(2) FINAL REPORT.—Not later than 1 year after the completion of the demonstration project, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration, in coordination with the Administrator of the Centers for Medicare & Medicaid Services, shall submit a report to Congress on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(i) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary and appropriate for the purpose of carrying out the demonstration project under this section.

(j) DEFINITIONS.—In this section:

(1) EXTENDED CARE SERVICES.—The term "extended care services" means the following:

(A) Home health services.

(B) Covered skilled nursing facility services.

(C) Hospice care.

(2) COVERED SKILLED NURSING FACILITY SERVICES.—The term "covered skilled nursing facility services" has the meaning given such term in

section 1888(e)(2)(A) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)).

(3) CRITICAL ACCESS HOSPITAL.—The term "critical access hospital" means a facility designated as a critical access hospital under section 1820(c) of such Act (42 U.S.C. 1395i–4(c)).

(4) HOME HEALTH SERVICES.—The term "home health services" has the meaning given such term in section 1861(m) of such Act (42 U.S.C. 1395x(m)).

(5) HOSPICE CARE.—The term "hospice care" has the meaning given such term in section 1861(dd) of such Act (42 U.S.C. 1395x(dd)).

(6) MEDICAID PROGRAM.—The term "Medicaid program" means the program under title XIX of such Act (42 U.S.C. 1396 et seq.).

(7) MEDICARE PROGRAM.—The term "Medicare program" means the program under title XVIII of such Act (42 U.S.C. 1395 et seq.).

(8) OTHER ESSENTIAL HEALTH CARE SERVICES.—The term "other essential health care services" means the following:

(A) Ambulance services (as described in section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7))).

(B) Rural health clinic services.

(C) Public health services (as defined by the Secretary).

(D) Other health care services determined appropriate by the Secretary.

(9) RURAL HEALTH CLINIC SERVICES.—The term "rural health clinic services" has the meaning given such term in section 1861(aa)(1) of such Act (42 U.S.C. 1395x(aa)(1)).

(10) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

SEC. 124. EXTENSION OF THE RECLASSIFICATION OF CERTAIN HOSPITALS.

(a) IN GENERAL.—Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note), as amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking "September 30, 2008" and inserting "September 30, 2009".

(b) SPECIAL EXCEPTION RECLASSIFICATIONS.—Section 117(a)(2) of the Medicare, Medicaid, and SCHIP Extension Act of 2008 (Public Law 110–173)) is amended by striking "September 30, 2008" and inserting "the last date of the extension of reclassifications under section

106(a) of the Medicare Improvement and Extension Act of 2006 (division B of Public Law 109–432)".

(c) DISREGARDING SECTION 508 HOSPITAL RECLASSIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICATIONS.—Section 508(g) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173, 42 U.S.C. 1395ww note), as added by section 117(b) of the Medicare, Medicaid, and SCHIP Extension Act of 2008 (Public Law 110–173)), is amended by striking "during fiscal year 2008" and inserting "beginning on October 1, 2007, and ending on the last date of the extension of reclassifications under section 106(a) of the Medicare Improvement and Extension Act of 2006 (division B of Public Law 109–432)".

SEC. 125. REVOCATION OF UNIQUE DEEMING AUTHORITY OF THE JOINT COMMISSION.

(a) REVOCATION.—Section 1865 of the Social Security Act (42 U.S.C. 1395bb) is amended—

(1) by striking subsection (a); and

(2) by redesignating subsections (b), (c), (d), and (e) as subsections (a), (b), (c), and (d), respectively.

(b) CONFORMING AMENDMENTS.—(1) Section 1865 of the Social Security Act (42 U.S.C. 1395bb) is amended—

(A) in subsection (a)(1), as redesignated by subsection (a)(2), by striking "In addition, if" and inserting "If";

(B) in subsection (b), as so redesignated—

(i) by striking "released to him by the Joint Commission on Accreditation of Hospitals," and inserting "released to the Secretary by"; and

(ii) by striking the comma after "Association";

(C) in subsection (c), as so redesignated, by striking "pursuant to subsection (a) or (b)(1)" and inserting "pursuant to subsection (a)(1)"; and

(D) in subsection (d), as so redesignated, by striking "pursuant to subsection (a) or (b)(1)" and inserting "pursuant to subsection (a)(1)".

(2) Section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)) is amended in the fourth sentence by striking "and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals" and inserting "and (ii) is ac-

credited by a national accreditation body recognized by the Secretary under section 1865(a), or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of such a national accreditation body.".

(3) Section 1864(c) of the Social Security Act (42 U.S.C. 1395aa(c)) is amended by striking "pursuant to subsection (a) or (b)(1) of section 1865" and inserting "pursuant to section 1865(a)(1)".

(4) Section 1875(b) of the Social Security Act (42 U.S.C. 1395ll(b)) is amended by striking "the Joint Commission on Accreditation of Hospitals," and inserting "national accreditation bodies under section 1865(a)".

(5) Section 1834(a)(20)(B) of the Social Security Act (42 U.S.C. 1395m(a)(20)(B)) is amended by striking "section 1865(b)" and inserting "section 1865(a)".

(6) Section 1852(e)(4)(C) of the Social Security Act (42 U.S.C. 1395w–22(e)(4)(C)) is amended by striking "section 1865(b)(2)" and inserting "section 1865(a)(2)".

(c) AUTHORITY TO RECOGNIZE THE JOINT COMMISSION AS A NATIONAL ACCREDITATION BODY.—The Secretary of Health and Human Services may recognize the Joint Commission as a national accreditation body under

section 1865 of the Social Security Act (42 U.S.C. 1395bb), as amended by this section, upon such terms and conditions, and upon submission of such information, as the Secretary may require.

(d) EFFECTIVE DATE; TRANSITION RULE.—(1) Subject to paragraph (2), the amendments made by this section shall apply with respect to accreditations of hospitals granted on or after the date that is 24 months after the date of the enactment of this Act.

(2) For purposes of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the amendments made by this section shall not effect the accreditation of a hospital by the Joint Commission, or under accreditation or comparable approval standards found to be essentially equivalent to accreditation or approval standards of the Joint Commission, for the period of time applicable under such accreditation.

Subtitle C—Provisions Relating to Part B

PART 1—PHYSICIANS' SERVICES

SEC. 131. PHYSICIAN PAYMENT, EFFICIENCY, AND QUALITY IMPROVEMENTS.

(a) IN GENERAL.—

(1) INCREASE IN UPDATE FOR THE SECOND HALF OF 2008 AND FOR 2009.—

(A) FOR THE SECOND HALF OF 2008.—Section 1848(d)(8) of the Social Security Act (42 U.S.C. 1395w–4(d)(8)), as added by section 101 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended—

(i) in the heading, by striking "A PORTION OF";

(ii) in subparagraph (A), by striking "for the period beginning on January 1, 2008, and ending on June 30, 2008,"; and

(iii) in subparagraph (B)—

(I) in the heading, by striking "THE REMAINING PORTION OF 2008 AND"; and

(II) by striking "for the period beginning on July 1, 2008, and ending on December 31, 2008, and".

(B) FOR 2009.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)), as amended by section 101 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by adding at the end the following new paragraph:

"(9) UPDATE FOR 2009.—

"(A) IN GENERAL.—Subject to paragraphs (7)(B) and (8)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2009, the update to the single conversion factor shall be 1.1 percent.

"(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2010 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2010 and subsequent years as if subparagraph (A) had never applied.".

(3) REVISION OF THE PHYSICIAN ASSISTANCE AND QUALITY INITIATIVE FUND.—

(A) IN GENERAL.—Subject to subparagraph (B), section 1848(l)(2) of the Social Security Act (42 U.S.C. 1395w–4(l)(2)), as amended by section 101(a)(2) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended—

(i) in subparagraph (A)—

(I) by striking clause (i)(III); and

(II) by striking clause (ii)(III); and

(ii) in subparagraph (B)—

(I) in clause (i), by adding "and" at the end;

(II) in clause (ii), by striking "; and" and inserting a period; and

(III) by striking clause (iii).

(B) CONTINGENCY.—If there is enacted, before, on, or after the date of the enactment of this Act, a Supplemental Appropriations Act, 2008 that includes a provision amending section 1848(l) of the Social Security Act, the alternative amendment described in subparagraph (C)—

(i) shall apply instead of the amendments made by subparagraph (A); and

(ii) shall be executed after such provision in such Supplemental Appropriations Act.

(C) ALTERNATIVE AMENDMENT DESCRIBED.—The alternative amendment described in this subparagraph is as follows: Section 1848(l)(2) of the Social Security Act (42 U.S.C. 1395w–4(l)(2)), as amended by section 101(a)(2) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law

110–173) and by the Supplemental Appropriations Act, 2008, is amended—

(i) in subparagraph (A)—

(I) by striking subclauses (III) and (IV) of clause (i); and

(II) by striking subclauses (III) and (IV) of clause (ii); and

(ii) in subparagraph (B)—

(I) in clause (i), by adding "and" at the end;

(II) in clause (ii), by striking the semicolon at the end and inserting a period; and

(III) by striking clauses (iii) and (iv).

(b) EXTENSION AND IMPROVEMENT OF THE QUALITY REPORTING SYSTEM.—

(1) SYSTEM.—Section 1848(k)(2) of the Social Security Act (42 U.S.C. 1395w–4(k)(2)), as amended by section 101(b)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by adding at the end the following new subparagraphs:

"(C) FOR 2010 AND SUBSEQUENT YEARS.—

"(i) IN GENERAL.—Subject to clause (ii), for purposes of reporting data on quality measures for covered professional services furnished during 2010 and each subsequent year, subject to subsection (m)(3)(C), the quality measures (including electronic prescribing quality measures) specified under this paragraph shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

"(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance.

"(D) OPPORTUNITY TO PROVIDE INPUT ON MEASURES FOR 2009 AND SUBSEQUENT YEARS.—For each quality measure (including an electronic prescribing quality measure) adopted by the Secretary under subparagraph (B) (with respect to 2009) or subparagraph (C), the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish.".

(2) REDESIGNATION OF REPORTING SYSTEM.—Subsection (c) of section 101 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4 note), as amended by section 101(b)(2) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is redesignated as subsection (m) of section 1848 of the Social Security Act.

(3) INCENTIVE PAYMENTS UNDER REPORTING SYSTEM.—Section 1848(m) of the Social Security Act, as redesignated by paragraph (2), is amended—

(A) by amending the heading to read as follows: "INCENTIVE PAYMENTS FOR QUALITY REPORTING";

(B) by striking paragraph (1) and inserting the following:

"(1) INCENTIVE PAYMENTS.—

"(A) IN GENERAL.—For 2007 through 2010, with respect to covered professional services furnished during a reporting period by an eligible professional, if—

"(i) there are any quality measures that have been established under the physician reporting system that are applicable to any such services furnished by such professional for such reporting period; and

"(ii) the eligible professional satisfactorily submits (as determined under this subsection) to the Secretary data on such quality measures in accordance with such reporting system for such reporting period,

in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) or, in the case of a group practice under paragraph (3)(C), to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section

1841 an amount equal to the applicable quality percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the reporting period) of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (3)(C), by the group practice) during the reporting period.

"(B) APPLICABLE QUALITY PERCENT.—For purposes of subparagraph (A), the term 'applicable quality percent' means—

"(i) for 2007 and 2008, 1.5 percent; and

"(ii) for 2009 and 2010, 2.0 percent.";

(C) by striking paragraph (3) and redesignating paragraph (2) as paragraph (3);

(D) in paragraph (3), as so redesignated—

(i) in the matter preceding subparagraph (A), by striking "For purposes" and inserting the following:

"(A) IN GENERAL.—For purposes";

(ii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respec-

tively, and moving the indentation of such clauses 2 ems to the right;

(iii) in subparagraph (A), as added by clause (i), by adding at the end the following flush sentence:

"For years after 2008, quality measures for purposes of this subparagraph shall not include electronic prescribing quality measures."; and

(iv) by adding at the end the following new subparagraphs:

"(C) SATISFACTORY REPORTING MEASURES FOR GROUP PRACTICES.—

"(i) IN GENERAL.—By January 1, 2010, the Secretary shall establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under subparagraph (A) and as meeting the requirement described in subparagraph (B)(ii) for covered professional services for a reporting period (or, for purposes of subsection (a)(5), for a reporting period for a year) if, in lieu of reporting measures under subsection (k)(2)(C), the

group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary.

"(ii) STATISTICAL SAMPLING MODEL.—The process under clause (i) shall provide for the use of a statistical sampling model to submit data on measures, such as the model used under the Physician Group Practice demonstration project under section 1866A.

"(iii) NO DOUBLE PAYMENTS.—Payments to a group practice under this subsection by reason of the process under clause (i) shall be in lieu of the payments that would otherwise be made under this subsection to eligible professionals in the group practice for satisfactorily submitting data on quality measures.

"(D) AUTHORITY TO REVISE SATISFACTORILY REPORTING DATA.—For years after 2009, the Secretary, in consultation with stakeholders and experts, may revise the criteria

under this subsection for satisfactorily submitting data on quality measures under subparagraph (A) and the criteria for submitting data on electronic prescribing quality measures under subparagraph (B)(ii).";

(E) in paragraph (5)—

(i) in subparagraph (C), by inserting "for 2007, 2008, and 2009," after "provision of law,";

(ii) in subparagraph (D)—

(I) in clause (i)—

(aa) by inserting "for 2007 and 2008" after "under this subsection"; and

(bb) by striking "paragraph (2)" and inserting "this subsection";

(II) in clause (ii), by striking "shall" and inserting "may establish procedures to"; and

(III) in clause (iii)—

(aa) by inserting "(or, in the case of a group practice under paragraph (3)(C), the group

practice)'' after ''an eligible professional'';

(bb) by striking ''bonus incentive payment'' and inserting ''incentive payment under this subsection''; and

(cc) by adding at the end the following new sentence: ''If such payments for such period have already been made, the Secretary shall recoup such payments from the eligible professional (or the group practice).'';

(iii) in subparagraph (E)—

(I) by striking ''(I) IN GENERAL.—'';

(II) by striking clause (ii);

(III) by redesignating subclauses (I) through (IV) as clauses (i) through (iv), respectively, and moving the indentation of such clauses 2 ems to the left;

(IV) in clause (ii), as so redesignated, by striking ''paragraph (2)'' and inserting ''this subsection''; and

(V) in clause (iv), as so redesignated—

(aa) by striking "the bonus" and inserting "any"; and

(bb) by inserting "and the payment adjustment under subsection (a)(5)(A)" before the period at the end;

(iv) in subparagraph (F)—

(I) by striking "2009, paragraph (3) shall not apply, and" and inserting "subsequent years,"; and

(II) by striking "paragraph (2)" and inserting "this subsection"; and

(v) by adding at the end the following new subparagraph:

"(G) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the following:

"(i) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who satisfac-

torily submitted data on quality measures under this subsection.

"(ii) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who are successful electronic prescribers."; and

(F) in paragraph (6), by striking subparagraph (C) and inserting the following:

"(C) REPORTING PERIOD.—

"(i) IN GENERAL.—Subject to clauses (ii) and (iii), the term 'reporting period' means—

"(I) for 2007, the period beginning on July 1, 2007, and ending on December 31, 2007; and

"(II) for 2008, 2009, 2010, and 2011, the entire year.

"(ii) AUTHORITY TO REVISE REPORTING PERIOD.—For years after 2009, the Secretary may revise the reporting period under clause (i) if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing ad-

ministrative burden. If the Secretary revises such period pursuant to the preceding sentence, the term 'reporting period' shall mean such revised period.

"(iii) REFERENCE.—Any reference in this subsection to a reporting period with respect to the application of subsection (a)(5) shall be deemed a reference to the reporting period under subparagraph (D)(iii) of such subsection.".

(4) INCLUSION OF QUALIFIED AUDIOLOGISTS AS ELIGIBLE PROFESSIONALS.—

(A) IN GENERAL.—Section 1848(k)(3)(B) of the Social Security Act (42 U.S.C. 1395w–4(k)(3)(B)), is amended by adding at the end the following new clause:

"(iv) Beginning with 2009, a qualified audiologist (as defined in section 1861(ll)(3)(B)).".

(B) NO CHANGE IN BILLING.—Nothing in the amendment made by subparagraph (A) shall be construed to change the way in which billing for audiology services (as defined in section 1861(ll)(2) of the Social Security Act (42

U.S.C. 1395x(ll)(2))) occurs under title XVIII of such Act as of July 1, 2008.

(5) CONFORMING AMENDMENTS.—Section 1848(m) of the Social Security Act, as added and amended by paragraphs (2) and (3), is amended—

(A) in paragraph (5)—

(i) in subparagraph (A)—

(I) by striking "section 1848(k) of the Social Security Act, as added by subsection (b)," and inserting "subsection (k)"; and

(II) by striking "such section" and inserting "such subsection";

(ii) in subparagraph (B), by striking "of the Social Security Act (42 U.S.C. 1395l)";

(iii) in subparagraph (E), in the matter preceding clause (i), by striking "1869 or 1878 of the Social Security Act or otherwise" and inserting "1869, section 1878, or otherwise"; and

(iv) in subparagraph (F)—

(I) by striking "paragraph (2)(B) of section 1848(k) of the Social Secu-

rity Act (42 U.S.C. 1395w–4(k))" and inserting "subsection (k)(2)(B)"; and

(II) by striking "paragraph (4) of such section" and inserting "subsection (k)(4)";

(B) in paragraph (6)—

(i) in subparagraph (A), by striking "section 1848(k)(3) of the Social Security Act, as added by subsection (b)" and inserting "subsection (k)(3)"; and

(ii) in subparagraph (B), by striking "section 1848(k) of the Social Security Act, as added by subsection (b)" and inserting "subsection (k)"; and

(C) by striking paragraph (6)(D).

(6) NO AFFECT ON INCENTIVE PAYMENTS FOR 2007 OR 2008.—Nothing in the amendments made by this subsection or section 132 shall affect the operation of the provisions of section 1848(m) of the Social Security Act, as redesignated and amended by such subsection and section, with respect to 2007 or 2008.

(c) PHYSICIAN FEEDBACK PROGRAM TO IMPROVE EFFICIENCY AND CONTROL COSTS.—

(1) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsection (b), is amended by adding at the end the following new subsection:

"(n) PHYSICIAN FEEDBACK PROGRAM.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary shall establish a Physician Feedback Program (in this subsection referred to as the 'Program') under which the Secretary shall use claims data under this title (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this title. If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this title by the physician (or group of physicians) in such reports.

"(B) RESOURCE USE.—The resources described in subparagraph (A) may be measured—

"(i) on an episode basis;

"(ii) on a per capita basis; or

"(iii) on both an episode and a per capita basis.

"(2) IMPLEMENTATION.—The Secretary shall implement the Program by not later than January 1, 2009.

"(3) DATA FOR REPORTS.—To the extent practicable, reports under the Program shall be based on the most recent data available.

"(4) AUTHORITY TO FOCUS APPLICATION.—The Secretary may focus the application of the Program as appropriate, such as focusing the Program on—

"(A) physician specialties that account for a certain percentage of all spending for physicians' services under this title;

"(B) physicians who treat conditions that have a high cost or a high volume, or both, under this title;

"(C) physicians who use a high amount of resources compared to other physicians;

"(D) physicians practicing in certain geographic areas; or

"(E) physicians who treat a minimum number of individuals under this title.

"(5) AUTHORITY TO EXCLUDE CERTAIN INFORMATION IF INSUFFICIENT INFORMATION.—The Sec-

retary may exclude certain information regarding a service from a report under the Program with respect to a physician (or group of physicians) if the Secretary determines that there is insufficient information relating to that service to provide a valid report on that service.

"(6) ADJUSTMENT OF DATA.—To the extent practicable, the Secretary shall make appropriate adjustments to the data used in preparing reports under the Program, such as adjustments to take into account variations in health status and other patient characteristics.

"(7) EDUCATION AND OUTREACH.—The Secretary shall provide for education and outreach activities to physicians on the operation of, and methodologies employed under, the Program.

"(8) DISCLOSURE EXEMPTION.—Reports under the Program shall be exempt from disclosure under section 552 of title 5, United States Code.".

(2) GAO STUDY AND REPORT ON THE PHYSICIAN FEEDBACK PROGRAM.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study of the Physician Feedback Program conducted under section 1848(n) of the Social Security Act, as

added by paragraph (1), including the implementation of the Program.

(B) REPORT.—Not later than March 1, 2011, the Comptroller General of the United States shall submit a report to Congress containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(d) PLAN FOR TRANSITION TO VALUE-BASED PURCHASING PROGRAM FOR PHYSICIANS AND OTHER PRACTITIONERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a plan to transition to a value-based purchasing program for payment under the Medicare program for covered professional services (as defined in section 1848(k)(3)(A) of the Social Security Act (42 U.S.C. 1395w–4(k)(3)(A))).

(2) REPORT.—Not later than May 1, 2010, the Secretary of Health and Human Services shall submit a report to Congress containing the plan developed under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 132. INCENTIVES FOR ELECTRONIC PRESCRIBING.

(a) INCENTIVE PAYMENTS.—Section 1848(m) of the Social Security Act, as added and amended by section 131(b), is amended—

(1) by inserting after paragraph (1), the following new paragraph:

"(2) INCENTIVE PAYMENTS FOR ELECTRONIC PRESCRIBING.—

"(A) IN GENERAL.—For 2009 through 2013, with respect to covered professional services furnished during a reporting period by an eligible professional, if the eligible professional is a successful electronic prescriber for such reporting period, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) or, in the case of a group practice under paragraph (3)(C), to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 an amount equal to the applicable electronic prescribing percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the reporting period) of the allowed charges

under this part for all such covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (3)(C), by the group practice) during the reporting period.

"(B) LIMITATION WITH RESPECT TO ELECTRONIC PRESCRIBING QUALITY MEASURES.—The provisions of this paragraph and subsection (a)(5) shall not apply to an eligible professional (or, in the case of a group practice under paragraph (3)(C), to the group practice) if, for the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year)—

"(i) the allowed charges under this part for all covered professional services furnished by the eligible professional (or group, as applicable) for the codes to which the electronic prescribing quality measure applies (as identified by the Secretary and published on the Internet website of the Centers for Medicare & Medicaid Services as of January 1, 2008, and as subsequently modified by the Secretary) are less than 10 percent of the total of the allowed charges under this part

for all such covered professional services furnished by the eligible professional (or the group, as applicable); or

"(ii) if determined appropriate by the Secretary, the eligible professional does not submit (including both electronically and nonelectronically) a sufficient number (as determined by the Secretary) of prescriptions under part D.

If the Secretary makes the determination to apply clause (ii) for a period, then clause (i) shall not apply for such period.

"(C) APPLICABLE ELECTRONIC PRESCRIBING PERCENT.—For purposes of subparagraph (A), the term 'applicable electronic prescribing percent' means—

"(i) for 2009 and 2010, 2.0 percent;

"(ii) for 2011 and 2012, 1.0 percent; and

"(iii) for 2013, 0.5 percent.";

(2) in paragraph (3), as redesignated by section 131(b)—

(A) in the heading, by inserting "AND SUCCESSFUL ELECTRONIC PRESCRIBER" after "REPORTING"; and

(B) by inserting after subparagraph (A) the following new subparagraph:

"(B) SUCCESSFUL ELECTRONIC PRESCRIBER.—

"(i) IN GENERAL.—For purposes of paragraph (2) and subsection (a)(5), an eligible professional shall be treated as a successful electronic prescriber for a reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year) if the eligible professional meets the requirement described in clause (ii), or, if the Secretary determines appropriate, the requirement described in clause (iii). If the Secretary makes the determination under the preceding sentence to apply the requirement described in clause (iii) for a period, then the requirement described in clause (ii) shall not apply for such period.

"(ii) REQUIREMENT FOR SUBMITTING DATA ON ELECTRONIC PRESCRIBING QUALITY MEASURES.—The requirement described in this clause is that, with respect to covered professional services furnished by an eligible professional during a report-

ing period (or, for purposes of subsection (a)(5), for the reporting period for a year), if there are any electronic prescribing quality measures that have been established under the physician reporting system and are applicable to any such services furnished by such professional for the period, such professional reported each such measure under such system in at least 50 percent of the cases in which such measure is reportable by such professional under such system.

"(iii) REQUIREMENT FOR ELECTRONICALLY PRESCRIBING UNDER PART D.—The requirement described in this clause is that the eligible professional electronically submitted a sufficient number (as determined by the Secretary) of prescriptions under part D during the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year).

"(iv) USE OF PART D DATA.—Notwithstanding sections 1860D–15(d)(2)(B) and 1860D–15(f)(2), the Secretary may use data regarding drug claims submitted

for purposes of section 1860D–15 that are necessary for purposes of clause (iii), paragraph (2)(B)(ii), and paragraph (5)(G).

"(v) STANDARDS FOR ELECTRONIC PRESCRIBING.—To the extent practicable, in determining whether eligible professionals meet the requirements under clauses (ii) and (iii) for purposes of clause (i), the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1860D–4(e)."; and

(3) in paragraph (5)(E), by striking clause (iii) and inserting the following new clause:

"(iii) the determination of a successful electronic prescriber under paragraph (3), the limitation under paragraph (2)(B), and the exception under subsection (a)(5)(B); and".

(b) INCENTIVE PAYMENT ADJUSTMENT.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following new paragraph:

"(5) INCENTIVES FOR ELECTRONIC PRESCRIBING.—

"(A) ADJUSTMENT.—

"(i) IN GENERAL.—Subject to subparagraph (B) and subsection (m)(2)(B), with respect to covered professional services furnished by an eligible professional during 2012 or any subsequent year, if the eligible professional is not a successful electronic prescriber for the reporting period for the year (as determined under subsection (m)(3)(B)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).

"(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term 'applicable percent' means—

"(I) for 2012, 99 percent;

"(II) for 2013, 98.5 percent; and

"(III) for 2014 and each subsequent year, 98 percent.

"(B) SIGNIFICANT HARDSHIP EXCEPTION.—The Secretary may, on a case-by-case basis, exempt an eligible professional from the application of the payment adjustment under subparagraph (A) if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access.

"(C) APPLICATION.—

"(i) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

"(ii) INCENTIVE PAYMENT VALIDATION RULES.—Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes

of this paragraph in a similar manner as they apply for purposes of such subsection.

"(D) DEFINITIONS.—For purposes of this paragraph:

"(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms 'eligible professional' and 'covered professional services' have the meanings given such terms in subsection (k)(3).

"(ii) PHYSICIAN REPORTING SYSTEM.—The term 'physician reporting system' means the system established under subsection (k).

"(iii) REPORTING PERIOD.—The term 'reporting period' means, with respect to a year, a period specified by the Secretary.".

(c) GAO REPORT ON ELECTRONIC PRESCRIBING.—Not later than September 1, 2012, the Comptroller General of the United States shall submit to Congress a report on the implementation of the incentives for electronic prescribing established under the provisions of, and amendments made by, this section. Such report shall include information regarding the following:

(1) The percentage of eligible professionals (as defined in section 1848(k)(3) of the Social Security

Act (42 U.S.C. 1395w–4(k)(3)) that are using electronic prescribing systems, including a determination of whether less than 50 percent of eligible professionals are using electronic prescribing systems.

(2) If less than 50 percent of eligible professionals are using electronic prescribing systems, recommendations for increasing the use of electronic prescribing systems by eligible professionals, such as changes to the incentive payment adjustments established under section 1848(a)(5) of such Act, as added by subsection (b).

(3) The estimated savings to the Medicare program under title XVIII of such Act resulting from the use of electronic prescribing systems.

(4) Reductions in avoidable medical errors resulting from the use of electronic prescribing systems.

(5) The extent to which the privacy and security of the personal health information of Medicare beneficiaries is protected when such beneficiaries' prescription drug data and usage information is used for purposes other than their direct clinical care, including—

(A) whether information identifying the beneficiary is, and remains, removed from data

regarding the beneficiary's prescription drug utilization; and

(B) the extent to which current law requires sufficient and appropriate oversight and audit capabilities to monitor the practice of prescription drug data mining.

(6) Such other recommendations and administrative action as the Comptroller General determines to be appropriate.

SEC. 133. EXPANDING ACCESS TO PRIMARY CARE SERVICES.

(a) REVISIONS TO THE MEDICARE MEDICAL HOME DEMONSTRATION PROJECT.—

(1) AUTHORITY TO EXPAND.—Section 204(b) of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395b–1 note) is amended—

(A) in paragraph (1), by striking "The project" and inserting "Subject to paragraph (3), the project"; and

(B) by adding at the end the following new paragraph:

"(3) EXPANSION.—The Secretary may expand the duration and the scope of the project under paragraph (1), to an extent determined appropriate by the Secretary, if the Secretary determines that

such expansion will result in any of the following conditions being met:

"(A) The expansion of the project is expected to improve the quality of patient care without increasing spending under the Medicare program (not taking into account amounts available under subsection (g)).

"(B) The expansion of the project is expected to reduce spending under the Medicare program (not taking into account amounts available under subsection (g)) without reducing the quality of patient care.".

(2) FUNDING AND APPLICATION.—Section 204 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395b–1 note) is amended by adding at the end the following new subsections:

"(g) FUNDING FROM SMI TRUST FUND.—There shall be available, from the Federal Supplementary Medical Insurance Trust Fund (under section 1841 of the Social Security Act (42 U.S.C. 1395t)), the amount of $100,000,000 to carry out the project.

"(h) APPLICATION.—Chapter 35 of title 44, United States Code, shall not apply to the conduct of the project.".

(b) APPLICATION OF BUDGET-NEUTRALITY ADJUSTOR TO CONVERSION FACTOR.—Section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) is amended by adding at the end the following new clause:

"(vi) ALTERNATIVE APPLICATION OF BUDGET-NEUTRALITY ADJUSTMENT.—Notwithstanding subsection (d)(9)(A), effective for fee schedules established beginning with 2009, with respect to the 5-year review of work relative value units used in fee schedules for 2007 and 2008, in lieu of continuing to apply budget-neutrality adjustments required under clause (ii) for 2007 and 2008 to work relative value units, the Secretary shall apply such budget-neutrality adjustments to the conversion factor otherwise determined for years beginning with 2009.".

SEC. 134. EXTENSION OF FLOOR ON MEDICARE WORK GEOGRAPHIC ADJUSTMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)), as amended by section 103 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is

amended by striking "before July 1, 2008" and inserting "before January 1, 2010".

(b) TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN CERTAIN AREAS.—Section 1848(e)(1)(G) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(G)) is amended by adding at the end the following new sentence: "For purposes of payment for services furnished in the State described in the preceding sentence on or after January 1, 2009, after calculating the work geographic index in subparagraph (A)(iii), the Secretary shall increase the work geographic index to 1.5 if such index would otherwise be less than 1.5".

(c) TECHNICAL CORRECTION.—Section 602(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2301) is amended to read as follows:

"(1) in subparagraph (A), by striking 'subparagraphs (B), (C), and (E)' and inserting 'subparagraphs (B), (C), (E), and (G)'; and".

SEC. 135. IMAGING PROVISIONS.

(a) ACCREDITATION REQUIREMENT.—

(1) ACCREDITATION REQUIREMENT.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by inserting after subsection (d) the following new subsection:

"(e) ACCREDITATION REQUIREMENT FOR ADVANCED DIAGNOSTIC IMAGING SERVICES.—

"(1) IN GENERAL.—

"(A) IN GENERAL.—Beginning with January 1, 2012, with respect to the technical component of advanced diagnostic imaging services for which payment is made under the fee schedule established under section 1848(b) and that are furnished by a supplier, payment may only be made if such supplier is accredited by an accreditation organization designated by the Secretary under paragraph (2)(B)(i).

"(B) ADVANCED DIAGNOSTIC IMAGING SERVICES DEFINED.—In this subsection, the term 'advanced diagnostic imaging services' includes—

"(i) diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine (including positron emission tomography); and

"(ii) such other diagnostic imaging services, including services described in section 1848(b)(4)(B) (excluding X-ray, ultrasound, and fluoroscopy), as specified by the Secretary in consultation with phy-

sician specialty organizations and other stakeholders.

"(C) SUPPLIER DEFINED.—In this subsection, the term 'supplier' has the meaning given such term in section 1861(d).

"(2) ACCREDITATION ORGANIZATIONS.—

"(A) FACTORS FOR DESIGNATION OF ACCREDITATION ORGANIZATIONS.—The Secretary shall consider the following factors in designating accreditation organizations under subparagraph (B)(i) and in reviewing and modifying the list of accreditation organizations designated pursuant to subparagraph (C):

"(i) The ability of the organization to conduct timely reviews of accreditation applications.

"(ii) Whether the organization has established a process for the timely integration of new advanced diagnostic imaging services into the organization's accreditation program.

"(iii) Whether the organization uses random site visits, site audits, or other strategies for ensuring accredited suppliers

maintain adherence to the criteria described in paragraph (3).

"(iv) The ability of the organization to take into account the capacities of suppliers located in a rural area (as defined in section 1886(d)(2)(D)).

"(v) Whether the organization has established reasonable fees to be charged to suppliers applying for accreditation.

"(vi) Such other factors as the Secretary determines appropriate.

"(B) DESIGNATION.—Not later than January 1, 2010, the Secretary shall designate organizations to accredit suppliers furnishing the technical component of advanced diagnostic imaging services. The list of accreditation organizations so designated may be modified pursuant to subparagraph (C).

"(C) REVIEW AND MODIFICATION OF LIST OF ACCREDITATION ORGANIZATIONS.—

"(i) IN GENERAL.—The Secretary shall review the list of accreditation organizations designated under subparagraph (B) taking into account the factors under subparagraph (A). Taking into account the re-

sults of such review, the Secretary may, by regulation, modify the list of accreditation organizations designated under subparagraph (B).

"(ii) SPECIAL RULE FOR ACCREDITATIONS DONE PRIOR TO REMOVAL FROM LIST OF DESIGNATED ACCREDITATION ORGANIZATIONS.—In the case where the Secretary removes an organization from the list of accreditation organizations designated under subparagraph (B), any supplier that is accredited by the organization during the period beginning on the date on which the organization is designated as an accreditation organization under subparagraph (B) and ending on the date on which the organization is removed from such list shall be considered to have been accredited by an organization designated by the Secretary under subparagraph (B) for the remaining period such accreditation is in effect.

"(3) CRITERIA FOR ACCREDITATION.—The Secretary shall establish procedures to ensure that the criteria used by an accreditation organization des-

ignated under paragraph (2)(B) to evaluate a supplier that furnishes the technical component of advanced diagnostic imaging services for the purpose of accreditation of such supplier is specific to each imaging modality. Such criteria shall include—

"(A) standards for qualifications of medical personnel who are not physicians and who furnish the technical component of advanced diagnostic imaging services;

"(B) standards for qualifications and responsibilities of medical directors and supervising physicians, including standards that recognize the considerations described in paragraph (4);

"(C) procedures to ensure that equipment used in furnishing the technical component of advanced diagnostic imaging services meets performance specifications;

"(D) standards that require the supplier have procedures in place to ensure the safety of persons who furnish the technical component of advanced diagnostic imaging services and individuals to whom such services are furnished;

"(E) standards that require the establishment and maintenance of a quality assurance

and quality control program by the supplier that is adequate and appropriate to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by such supplier; and

"(F) any other standards or procedures the Secretary determines appropriate.

"(4) RECOGNITION IN STANDARDS FOR THE EVALUATION OF MEDICAL DIRECTORS AND SUPERVISING PHYSICIANS.—The standards described in paragraph (3)(B) shall recognize whether a medical director or supervising physician—

"(A) in a particular specialty receives training in advanced diagnostic imaging services in a residency program;

"(B) has attained, through experience, the necessary expertise to be a medical director or a supervising physician;

"(C) has completed any continuing medical education courses relating to such services; or

"(D) has met such other standards as the Secretary determines appropriate.

"(5) RULE FOR ACCREDITATIONS MADE PRIOR TO DESIGNATION.—In the case of a supplier that is accredited before January 1, 2010, by an accredita-

tion organization designated by the Secretary under paragraph (2)(B) as of January 1, 2010, such supplier shall be considered to have been accredited by an organization designated by the Secretary under such paragraph as of January 1, 2012, for the remaining period such accreditation is in effect.".

(2) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(i) in paragraph (21), by striking "or" at the end;

(ii) in paragraph (22), by striking the period at the end and inserting "; or"; and

(iii) by inserting after paragraph (22) the following new paragraph:

"(23) which are the technical component of advanced diagnostic imaging services described in section 1834(e)(1)(B) for which payment is made under the fee schedule established under section 1848(b) and that are furnished by a supplier (as defined in section 1861(d)), if such supplier is not accredited by an accreditation organization designated by the Secretary under section 1834(e)(2)(B).".

(B) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to advanced diagnostic imaging services furnished on or after January 1, 2012.

(b) DEMONSTRATION PROJECT TO ASSESS THE APPROPRIATE USE OF IMAGING SERVICES.—

(1) CONDUCT OF DEMONSTRATION PROJECT.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct a demonstration project using the models described in paragraph (2)(E) to collect data regarding physician compliance with appropriateness criteria selected under paragraph (2)(D) in order to determine the appropriateness of advanced diagnostic imaging services furnished to Medicare beneficiaries.

(B) ADVANCED DIAGNOSTIC IMAGING SERVICES.—In this subsection, the term "advanced diagnostic imaging services" has the meaning given such term in section 1834(e)(1)(B) of the Social Security Act, as added by subsection (a).

(C) AUTHORITY TO FOCUS DEMONSTRATION PROJECT.—The Secretary may focus the

demonstration project with respect to certain advanced diagnostic imaging services, such as services that account for a large amount of expenditures under the Medicare program, services that have recently experienced a high rate of growth, or services for which appropriateness criteria exists.

(2) IMPLEMENTATION AND DESIGN OF DEMONSTRATION PROJECT.—

(A) IMPLEMENTATION AND DURATION.—

(i) IMPLEMENTATION.—The Secretary shall implement the demonstration project under this subsection not later than January 1, 2010.

(ii) DURATION.—The Secretary shall conduct the demonstration project under this subsection for a 2-year period.

(B) APPLICATION AND SELECTION OF PARTICIPATING PHYSICIANS.—

(i) APPLICATION.—Each physician that desires to participate in the demonstration project under this subsection shall submit an application to the Secretary at such time, in such manner, and

containing such information as the Secretary may require.

(ii) SELECTION.—The Secretary shall select physicians to participate in the demonstration project under this subsection from among physicians submitting applications under clause (i). The Secretary shall ensure that the physicians selected—

(I) represent a wide range of geographic areas, demographic characteristics (such as urban, rural, and suburban), and practice settings (such as private and academic practices); and

(II) have the capability to submit data to the Secretary (or an entity under a subcontract with the Secretary) in an electronic format in accordance with standards established by the Secretary.

(C) ADMINISTRATIVE COSTS AND INCENTIVES.—The Secretary shall—

(i) reimburse physicians for reasonable administrative costs incurred in participating in the demonstration project under this subsection; and

(ii) provide reasonable incentives to physicians to encourage participation in the demonstration project under this subsection.

(D) USE OF APPROPRIATENESS CRITERIA.—

(i) IN GENERAL.—The Secretary, in consultation with medical specialty societies and other stakeholders, shall select criteria with respect to the clinical appropriateness of advanced diagnostic imaging services for use in the demonstration project under this subsection.

(ii) CRITERIA SELECTED.—Any criteria selected under clause (i) shall—

(I) be developed or endorsed by a medical specialty society; and

(II) be developed in adherence to appropriateness principles developed by a consensus organization, such as the AQA alliance.

(E) MODELS FOR COLLECTING DATA REGARDING PHYSICIAN COMPLIANCE WITH SELECTED CRITERIA.—Subject to subparagraph (H), in carrying out the demonstration project

under this subsection, the Secretary shall use each of the following models for collecting data regarding physician compliance with appropriateness criteria selected under subparagraph (D):

(i) A model described in subparagraph (F).

(ii) A model described in subparagraph (G).

(iii) Any other model that the Secretary determines to be useful in evaluating the use of appropriateness criteria for advanced diagnostic imaging services.

(F) POINT OF SERVICE MODEL DESCRIBED.—A model described in this subparagraph is a model that—

(i) uses an electronic or paper intake form that—

(I) contains a certification by the physician furnishing the imaging service that the data on the intake form was confirmed with the Medicare beneficiary before the service was furnished;

(II) contains standardized data elements for diagnosis, service ordered, service furnished, and such other information determined by the Secretary, in consultation with medical specialty societies and other stakeholders, to be germane to evaluating the effectiveness of the use of appropriateness criteria selected under subparagraph (D); and

(III) is accessible to physicians participating in the demonstration project under this subsection in a format that allows for the electronic submission of such form; and

(ii) provides for feedback reports in accordance with paragraph (3)(B).

(G) POINT OF ORDER MODEL DESCRIBED.—A model described in this subparagraph is a model that—

(i) uses a computerized order-entry system that requires the transmittal of relevant supporting information at the time of referral for advanced diagnostic imaging services and provides automated decision-

support feedback to the referring physician regarding the appropriateness of furnishing such imaging services; and

(ii) provides for feedback reports in accordance with paragraph (3)(B).

(H) LIMITATION.—In no case may the Secretary use prior authorization—

(i) as a model for collecting data regarding physician compliance with appropriateness criteria selected under subparagraph (D) under the demonstration project under this subsection; or

(ii) under any model used for collecting such data under the demonstration project.

(I) REQUIRED CONTRACTS AND PERFORMANCE STANDARDS FOR CERTAIN ENTITIES.—

(i) IN GENERAL.—The Secretary shall enter into contracts with entities to carry out the model described in subparagraph (G).

(ii) PERFORMANCE STANDARDS.—The Secretary shall establish and enforce performance standards for such entities under the contracts entered into under clause (i),

including performance standards with respect to—

(I) the satisfaction of Medicare beneficiaries who are furnished advanced diagnostic imaging services by a physician participating in the demonstration project;

(II) the satisfaction of physicians participating in the demonstration project;

(III) if applicable, timelines for the provision of feedback reports under paragraph (3)(B); and

(IV) any other areas determined appropriate by the Secretary.

(3) COMPARISON OF UTILIZATION OF ADVANCED DIAGNOSTIC IMAGING SERVICES AND FEEDBACK REPORTS.—

(A) COMPARISON OF UTILIZATION OF ADVANCED DIAGNOSTIC IMAGING SERVICES.—The Secretary shall consult with medical specialty societies and other stakeholders to develop mechanisms for comparing the utilization of advanced diagnostic imaging services by physi-

cians participating in the demonstration project under this subsection against—

(i) the appropriateness criteria selected under paragraph (2)(D); and

(ii) to the extent feasible, the utilization of such services by physicians not participating in the demonstration project.

(B) FEEDBACK REPORTS.—The Secretary shall, in consultation with medical specialty societies and other stakeholders, develop mechanisms to provide feedback reports to physicians participating in the demonstration project under this subsection. Such feedback reports shall include—

(i) a profile of the rate of compliance by the physician with appropriateness criteria selected under paragraph (2)(D), including a comparison of—

(I) the rate of compliance by the physician with such criteria; and

(II) the rate of compliance by the physician's peers (as defined by the Secretary) with such criteria; and

(ii) to the extent feasible, a comparison of—

(I) the rate of utilization of advanced diagnostic imaging services by the physician; and

(II) the rate of utilization of such services by the physician's peers (as defined by the Secretary) who are not participating in the demonstration project.

(4) CONDUCT OF DEMONSTRATION PROJECT AND WAIVER.—

(A) CONDUCT OF DEMONSTRATION PROJECT.—Chapter 35 of title 44, United States Code, shall not apply to the conduct of the demonstration project under this subsection.

(B) WAIVER.—The Secretary may waive such provisions of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary to carry out the demonstration project under this subsection.

(5) EVALUATION AND REPORT.—

(A) EVALUATION.—The Secretary shall evaluate the demonstration project under this subsection to—

(i) assess the timeliness and efficacy of the demonstration project;

(ii) assess the performance of entities under a contract entered into under paragraph (2)(I)(i);

(iii) analyze data—

(I) on the rates of appropriate, uncertain, and inappropriate advanced diagnostic imaging services furnished by physicians participating in the demonstration project;

(II) on patterns and trends in the appropriateness and inappropriateness of such services furnished by such physicians;

(III) on patterns and trends in national and regional variations of care with respect to the furnishing of such services; and

(IV) on the correlation between the appropriateness of the services furnished and image results; and

(iv) address—

(I) the thresholds used under the demonstration project to identify ac-

ceptable and outlier levels of performance with respect to the appropriateness of advanced diagnostic imaging services furnished;

(II) whether prospective use of appropriateness criteria could have an effect on the volume of such services furnished;

(III) whether expansion of the use of appropriateness criteria with respect to such services to a broader population of Medicare beneficiaries would be advisable;

(IV) whether, under such an expansion, physicians who demonstrate consistent compliance with such appropriateness criteria should be exempted from certain requirements;

(V) the use of incident-specific versus practice-specific outlier information in formulating future recommendations with respect to the use of appropriateness criteria for such services under the Medicare program; and

(VI) the potential for using methods (including financial incentives), in addition to those used under the models under the demonstration project, to ensure compliance with such criteria.

(B) REPORT.—Not later than 1 year after the completion of the demonstration project under this subsection, the Secretary shall submit to Congress a report containing the results of the evaluation of the demonstration project conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(6) FUNDING.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of $10,000,000, for carrying out the demonstration project under this subsection (including costs associated with administering the demonstration project, reimbursing physicians for administrative costs and providing incentives to encourage participation under paragraph (2)(C), entering into contracts under

paragraph (2)(I), and evaluating the demonstration project under paragraph (5)).

(c) GAO STUDY AND REPORTS ON ACCREDITATION REQUIREMENT FOR ADVANCED DIAGNOSTIC IMAGING SERVICES.—

(1) STUDY.—

(A) IN GENERAL.—The Comptroller General of the United States (in this subsection referred to as the "Comptroller General") shall conduct a study, by imaging modality, on—

(i) the effect of the accreditation requirement under section 1834(e) of the Social Security Act, as added by subsection (a); and

(ii) any other relevant questions involving access to, and the value of, advanced diagnostic imaging services for Medicare beneficiaries.

(B) ISSUES.—The study conducted under subparagraph (A) shall examine the following:

(i) The impact of such accreditation requirement on the number, type, and quality of imaging services furnished to Medicare beneficiaries.

(ii) The cost of such accreditation requirement, including costs to facilities of compliance with such requirement and costs to the Secretary of administering such requirement.

(iii) Access to imaging services by Medicare beneficiaries, especially in rural areas, before and after implementation of such accreditation requirement.

(iv) Such other issues as the Secretary determines appropriate.

(2) REPORTS.—

(A) PRELIMINARY REPORT.—Not later than March 1, 2013, the Comptroller General shall submit a preliminary report to Congress on the study conducted under paragraph (1).

(B) FINAL REPORT.—Not later than March 1, 2014, the Comptroller General shall submit a final report to Congress on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SEC. 136. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–4 note), section 104 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4 note), and section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking "2007, and the first 6 months of 2008" and inserting "2007, 2008, and 2009".

SEC. 137. ACCOMMODATION OF PHYSICIANS ORDERED TO ACTIVE DUTY IN THE ARMED SERVICES.

Section 1842(b)(6)(D)(iii) of the Social Security Act (42 U.S.C. 1395u(b)(6)(D)(iii)), as amended by section 116 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking "(before July 1, 2008)".

SEC. 138. ADJUSTMENT FOR MEDICARE MENTAL HEALTH SERVICES.

(a) PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—For purposes of payment for services furnished under the physician fee schedule

under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) during the period beginning on July 1, 2008, and ending on December 31, 2009, the Secretary of Health and Human Services shall increase the fee schedule otherwise applicable for specified services by 5 percent.

(2) NONAPPLICATION OF BUDGET-NEUTRALITY.—The budget-neutrality provision of section 1848(c)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(ii)) shall not apply to the adjustments described in paragraph (1).

(b) DEFINITION OF SPECIFIED SERVICES.—In this section, the term "specified services" means procedure codes for services in the categories of the Health Care Common Procedure Coding System, established by the Secretary of Health and Human Services under section 1848(c)(5) of the Social Security Act (42 U.S.C. 1395w–4(c)(5)), as of July 1, 2007, and as subsequently modified by the Secretary, consisting of psychiatric therapeutic procedures furnished in office or other outpatient facility settings or in inpatient hospital, partial hospital, or residential care facility settings, but only with respect to such services in such categories that are in the subcategories of services which are—

(1) insight oriented, behavior modifying, or supportive psychotherapy; or

(2) interactive psychotherapy.

(c) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this section by program instruction or otherwise.

SEC. 139. IMPROVEMENTS FOR MEDICARE ANESTHESIA TEACHING PROGRAMS.

(a) SPECIAL PAYMENT RULE FOR TEACHING ANESTHESIOLOGISTS.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)), as amended by section 132(b), is amended—

(1) in paragraph (4)(A), by inserting "except as provided in paragraph (5)," after "anesthesia cases,"; and

(2) by adding at the end the following new paragraph:

"(6) SPECIAL RULE FOR TEACHING ANESTHESIOLOGISTS.—With respect to physicians' services furnished on or after January 1, 2010, in the case of teaching anesthesiologists involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount to be applied shall be 100 percent of the fee schedule amount otherwise applicable under this sec-

tion if the anesthesia services were personally performed by the teaching anesthesiologist alone and paragraph (4) shall not apply if—

"(A) the teaching anesthesiologist is present during all critical or key portions of the anesthesia service or procedure involved; and

"(B) the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.".

(b) TREATMENT OF CERTIFIED REGISTERED NURSE ANESTHETISTS.—With respect to items and services furnished on or after January 1, 2010, the Secretary of Health and Human Services shall make appropriate adjustments to payments under the Medicare program under title XVIII of the Social Security Act for teaching certified registered nurse anesthetists to implement a policy with respect to teaching certified registered nurse anesthetists that—

(1) is consistent with the adjustments made by the special rule for teaching anesthesiologists under section 1848(a)(6) of the Social Security Act, as added by subsection (a); and

(2) maintains the existing payment differences between teaching anesthesiologists and teaching certified registered nurse anesthetists.

PART 2—OTHER PAYMENT AND COVERAGE IMPROVEMENTS

SEC. 141. EXTENSION OF EXCEPTIONS PROCESS FOR MEDICARE THERAPY CAPS.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)), as amended by section 105 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking "June 30, 2008" and inserting "December 31, 2009".

SEC. 142. EXTENSION OF PAYMENT RULE FOR BRACHYTHERAPY AND THERAPEUTIC RADIOPHARMACEUTICALS.

Section 1833(t)(16)(C) of the Social Security Act (42 U.S.C. 1395l(t)(16)(C)), as amended by section 106 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking "July 1, 2008" each place it appears and inserting "January 1, 2010".

SEC. 143. SPEECH-LANGUAGE PATHOLOGY SERVICES.

(a) IN GENERAL.—Section 1861(ll) of the Social Security Act (42 U.S.C. 1395x(ll)) is amended—

(1) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively; and

(2) by inserting after paragraph (1) the following new paragraph:

"(2) The term 'outpatient speech-language pathology services' has the meaning given the term 'outpatient physical therapy services' in subsection (p), except that in applying such subsection—

"(A) 'speech-language pathology' shall be substituted for 'physical therapy' each place it appears; and

"(B) 'speech-language pathologist' shall be substituted for 'physical therapist' each place it appears.".

(b) CONFORMING AMENDMENTS.—

(1) Section 1832(a)(2)(C) of the Social Security Act (42 U.S.C. 1395k(a)(2)(C)) is amended—

(A) by striking "and outpatient" and inserting ", outpatient"; and

(B) by inserting before the semicolon at the end the following: ", and outpatient speech-language pathology services (other than services to which the second sentence of section 1861(p) applies through the application of section 1861(ll)(2))".

(2) Subparagraphs (A) and (B) of section 1833(a)(8) of the Social Security Act (42 U.S.C. 1395l(a)(8)) are each amended by striking "(which includes outpatient speech-language pathology services)" and inserting ", outpatient speech-language pathology services,".

(3) Section 1833(g)(1) of the Social Security Act (42 U.S.C. 1395l(g)(1)) is amended—

(A) by inserting "and speech-language pathology services of the type described in such section through the application of section 1861(ll)(2)" after "1861(p)"; and

(B) by inserting "and speech-language pathology services" after "and physical therapy services".

(4) The second sentence of section 1835(a) of the Social Security Act (42 U.S.C. 1395n(a)) is amended—

(A) by striking "section 1861(g)" and inserting "subsection (g) or (ll)(2) of section 1861" each place it appears; and

(B) by inserting "or outpatient speech-language pathology services, respectively" after "occupational therapy services".

(5) Section 1861(p) of the Social Security Act (42 U.S.C. 1395x(p)) is amended by striking the fourth sentence.

(6) Section 1861(s)(2)(D) of the Social Security Act (42 U.S.C. 1395x(s)(2)(D)) is amended by inserting ", outpatient speech-language pathology services," after "physical therapy services".

(7) Section 1862(a)(20) of the Social Security Act (42 U.S.C. 1395y(a)(20)) is amended—

(A) by striking "outpatient occupational therapy services or outpatient physical therapy services" and inserting "outpatient physical therapy services, outpatient speech-language pathology services, or outpatient occupational therapy services"; and

(B) by striking "section 1861(g)" and inserting "subsection (g) or (ll)(2) of section 1861".

(8) Section 1866(e)(1) of the Social Security Act (42 U.S.C. 1395cc(e)(1)) is amended—

(A) by striking "section 1861(g)" and inserting "subsection (g) or (ll)(2) of section 1861" the first two places it appears;

(B) by striking "defined) or" and inserting "defined),"; and

(C) by inserting before the semicolon at the end the following: ", or (through the operation of section 1861(ll)(2)) with respect to the furnishing of outpatient speech-language pathology".

(9) Section 1877(h)(6) of the Social Security Act (42 U.S.C. 1395nn(h)(6)) is amended by adding at the end the following new subparagraph:

"(L) Outpatient speech-language pathology services.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after July 1, 2009.

(d) CONSTRUCTION.—Nothing in this section shall be construed to affect existing regulations and policies of the Centers for Medicare & Medicaid Services that require physician oversight of care as a condition of payment for speech-language pathology services under part B of the Medicare program.

SEC. 144.

(a) COVERAGE OF PULMONARY AND CARDIAC REHABILITATION.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 101(a), is amended—

(A) in subsection (s)(2)—

(i) in subparagraph (AA), by striking "and" at the end;

(ii) by adding at the end the following new subparagraphs:

"(CC) items and services furnished under a cardiac rehabilitation program (as defined in subsection (eee)(1)) or under a pulmonary rehabilitation program (as defined in subsection (fff)(1)); and

"(DD) items and services furnished under an intensive cardiac rehabilitation program (as defined in subsection (eee)(4));"; and

(B) by adding at the end the following new subsections:

"Cardiac Rehabilitation Program; Intensive Cardiac Rehabilitation Program

"(eee)(1) The term 'cardiac rehabilitation program' means a physician-supervised program (as described in paragraph (2)) that furnishes the items and services described in paragraph (3).

"(2) A program described in this paragraph is a program under which—

"(A) items and services under the program are delivered—

"(i) in a physician's office;

"(ii) in a hospital on an outpatient basis; or

"(iii) in other settings determined appropriate by the Secretary.

"(B) a physician is immediately available and accessible for medical consultation and medical emergencies at all times items and services are being furnished under the program, except that, in the case of items and services furnished under such a program in a hospital, such availability shall be presumed; and

"(C) individualized treatment is furnished under a written plan established, reviewed, and signed by a physician every 30 days that describes—

"(i) the individual's diagnosis;

"(ii) the type, amount, frequency, and duration of the items and services furnished under the plan; and

"(iii) the goals set for the individual under the plan.

"(3) The items and services described in this paragraph are—

"(A) physician-prescribed exercise;

"(B) cardiac risk factor modification, including education, counseling, and behavioral intervention (to the extent such education, counseling, and behavioral intervention is closely related to the individual's care and treatment and is tailored to the individual's needs);

"(C) psychosocial assessment;

"(D) outcomes assessment; and

"(E) such other items and services as the Secretary may determine, but only if such items and services are—

"(i) reasonable and necessary for the diagnosis or active treatment of the individual's condition;

"(ii) reasonably expected to improve or maintain the individual's condition and functional level; and

"(iii) furnished under such guidelines relating to the frequency and duration of such items and services as the Secretary shall establish, taking into account accepted norms of medical practice and the reasonable expectation of improvement of the individual.

"(4)(A) The term 'intensive cardiac rehabilitation program' means a physician-supervised program (as de-

scribed in paragraph (2)) that furnishes the items and services described in paragraph (3) and has shown, in peer-reviewed published research, that it accomplished—

"(i) one or more of the following:

"(I) positively affected the progression of coronary heart disease; or

"(II) reduced the need for coronary bypass surgery; or

"(III) reduced the need for percutaneous coronary interventions; and

"(ii) a statistically significant reduction in 5 or more of the following measures from their level before receipt of cardiac rehabilitation services to their level after receipt of such services:

"(I) low density lipoprotein;

"(II) triglycerides;

"(III) body mass index;

"(IV) systolic blood pressure;

"(V) diastolic blood pressure; or

"(VI) the need for cholesterol, blood pressure, and diabetes medications.

"(B) To be eligible for an intensive cardiac rehabilitation program, an individual must have—

"(i) had an acute myocardial infarction within the preceding 12 months;

"(ii) had coronary bypass surgery;

"(iii) stable angina pectoris;

"(iv) had heart valve repair or replacement;

"(v) had percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or

"(vi) had a heart or heart-lung transplant.

"(C) An intensive cardiac rehabilitation program may be provided in a series of 72 one-hour sessions (as defined in section 1848(b)(5)), up to 6 sessions per day, over a period of up to 18 weeks.

"(5) The Secretary shall establish standards to ensure that a physician with expertise in the management of individuals with cardiac pathophysiology who is licensed to practice medicine in the State in which a cardiac rehabilitation program (or the intensive cardiac rehabilitation program, as the case may be) is offered—

"(A) is responsible for such program; and

"(B) in consultation with appropriate staff, is involved substantially in directing the progress of individual in the program.

"Pulmonary Rehabilitation Program

"(fff)(1) The term 'pulmonary rehabilitation program' means a physician-supervised program (as described in subsection (eee)(2) with respect to a program

under this subsection) that furnishes the items and services described in paragraph (2).

"(2) The items and services described in this paragraph are—

"(A) physician-prescribed exercise;

"(B) education or training (to the extent the education or training is closely and clearly related to the individual's care and treatment and is tailored to such individual's needs);

"(C) psychosocial assessment;

"(D) outcomes assessment; and

"(E) such other items and services as the Secretary may determine, but only if such items and services are—

"(i) reasonable and necessary for the diagnosis or active treatment of the individual's condition;

"(ii) reasonably expected to improve or maintain the individual's condition and functional level; and

"(iii) furnished under such guidelines relating to the frequency and duration of such items and services as the Secretary shall establish, taking into account accepted norms of

medical practice and the reasonable expectation of improvement of the individual.

"(3) The Secretary shall establish standards to ensure that a physician with expertise in the management of individuals with respiratory pathophysiology who is licensed to practice medicine in the State in which a pulmonary rehabilitation program is offered—

"(A) is responsible for such program; and

"(B) in consultation with appropriate staff, is involved substantially in directing the progress of individual in the program.".

(2) PAYMENT FOR INTENSIVE CARDIAC REHABILITATION PROGRAMS.—

(A) INCLUSION IN PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting "(2)(DD)," after "(2)(AA),".

(B) CONFORMING AMENDMENT.—Section 1848(b) of the Social Security Act (42 U.S.C. 1395w–4(b)) is amended by adding at the end the following new paragraph:

"(5) TREATMENT OF INTENSIVE CARDIAC REHABILITATION PROGRAM.—

"(A) IN GENERAL.—In the case of an intensive cardiac rehabilitation program described

in section 1861(eee)(4), the Secretary shall substitute the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department service under paragraph (3)(D) of section 1833(t) for cardiac rehabilitation (under HCPCS codes 93797 and 93798 for calendar year 2007, or any succeeding HCPCS codes for cardiac rehabilitation).

"(B) DEFINITION OF SESSION.—Each of the services described in subparagraphs (A) through (E) of section 1861(eee)(3), when furnished for one hour, is a separate session of intensive cardiac rehabilitation.

"(C) MULTIPLE SESSIONS PER DAY.—Payment may be made for up to 6 sessions per day of the series of 72 one-hour sessions of intensive cardiac rehabilitation services described in section 1861(eee)(4)(B).".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after January 1, 2010.

(b) REPEAL OF TRANSFER OF OWNERSHIP OF OXYGEN EQUIPMENT.—

(1) IN GENERAL.—Section 1834(a)(5)(F) of the Social Security Act (42 U.S.C. 1395m(a)(5)(F)) is amended—

(A) in the heading, by striking "OWNERSHIP OF EQUIPMENT" and inserting "RENTAL CAP"; and

(B) by striking clause (ii) and inserting the following:

"(ii) PAYMENTS AND RULES AFTER RENTAL CAP.—After the 36th continuous month during which payment is made for the equipment under this paragraph—

"(I) the supplier furnishing such equipment under this subsection shall continue to furnish the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment, as determined by the Secretary;

"(II) payments for oxygen shall continue to be made in the amount recognized for oxygen under paragraph (9) for the period of medical need; and

"(III) maintenance and servicing payments shall, if the Secretary determines such payments are reasonable and necessary, be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the equipment), and such payments shall be in an amount determined to be appropriate by the Secretary.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2009.

SEC. 145. CLINICAL LABORATORY TESTS.

(a) REPEAL OF MEDICARE COMPETITIVE BIDDING DEMONSTRATION PROJECT FOR CLINICAL LABORATORY SERVICES.—

(1) IN GENERAL.—Section 1847 of the Social Security Act (42 U.S.C. 1395w–3) is amended by striking subsection (e).

(2) CONFORMING AMENDMENTS.—Section 1833(a)(1)(D) of the Social Security Act (42 U.S.C. 1395l(a)(1)(D)) is amended—

(A) by inserting "or" before "(ii)"; and

(B) by striking "or (iii) on the basis" and all that follows before the comma at the end.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

(b) CLINICAL LABORATORY TEST FEE SCHEDULE UPDATE ADJUSTMENT.—Section 1833(h)(2)(A)(i) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)(ii)) is amended by inserting "minus, for each of the years 2009 through 2013, 0.5 percentage points" after "city average)".

SEC. 146. IMPROVED ACCESS TO AMBULANCE SERVICES.

(a) EXTENSION OF INCREASED MEDICARE PAYMENTS FOR GROUND AMBULANCE SERVICES.—Section 1834(l)(13) of the Social Security Act (42 U.S.C. 1395m(l)(13)) is amended—

(1) in subparagraph (A)—

(A) in the matter preceding clause (i), by inserting "and for such services furnished on or after July 1, 2008, and before January 1, 2010" after "2007,";

(B) in clause (i), by inserting "(or 3 percent if such service is furnished on or after July 1, 2008, and before January 1, 2010)" after "2 percent"; and

(C) in clause (ii), by inserting "(or 2 percent if such service is furnished on or after July 1, 2008, and before January 1, 2010)" after "1 percent"; and

(2) in subparagraph (B)—

(A) in the heading, by striking "2006" and inserting "APPLICABLE PERIOD"; and

(B) by inserting "applicable" before "period".

(b) AIR AMBULANCE PAYMENT IMPROVEMENTS.—

(1) TREATMENT OF CERTAIN AREAS FOR PAYMENT FOR AIR AMBULANCE SERVICES UNDER THE AMBULANCE FEE SCHEDULE.—Notwithstanding any other provision of law, for purposes of making payments under section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)) for air ambulance services furnished during the period beginning on July 1, 2008, and ending on December 31, 2009, any area that was designated as a rural area for purposes of making payments under such section for air ambulance services furnished on December 31, 2006, shall be treated as a rural area for purposes of making payments under such section for air ambulance services furnished during such period.

(2) CLARIFICATION REGARDING SATISFACTION OF REQUIREMENT OF MEDICALLY NECESSARY.—

(A) IN GENERAL.—Section 1834(l)(14)(B)(i) of the Social Security Act (42 U.S.C. 1395m(l)(14)(B)(i)) is amended by striking "reasonably determines or certifies" and inserting "certifies or reasonably determines".

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to services furnished on or after the date of the enactment of this Act.

SEC. 147. EXTENSION AND EXPANSION OF THE MEDICARE HOLD HARMLESS PROVISION UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT (HOPD) SERVICES FOR CERTAIN HOSPITALS.

Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) in subclause (II)—

(A) in the first sentence, by striking "2009" and inserting "2010"; and

(B) by striking the second sentence and inserting the following new sentence: "For purposes of the preceding sentence, the applicable

percentage shall be 95 percent with respect to covered OPD services furnished in 2006, 90 percent with respect to such services furnished in 2007, and 85 percent with respect to such services furnished in 2008 or 2009."; and

(2) by adding at the end the following new subclause:

"(III) In the case of a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) that has not more than 100 beds, for covered OPD services furnished on or after January 1, 2009, and before January 1, 2010, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by 85 percent of the amount of such difference.".

SEC. 148. CLARIFICATION OF PAYMENT FOR CLINICAL LABORATORY TESTS FURNISHED BY CRITICAL ACCESS HOSPITALS.

(a) IN GENERAL.—Section 1834(g)(4) of the Social Security Act (42 U.S.C. 1395m(g)(4)) is amended—

(1) in the heading, by striking "NO BENEFICIARY COST-SHARING FOR" and inserting "TREATMENT OF"; and

(2) by adding at the end the following new sentence: "For purposes of the preceding sentence and section 1861(mm)(3), clinical diagnostic laboratory services furnished by a critical access hospital shall be treated as being furnished as part of outpatient critical access services without regard to whether the individual with respect to whom such services are furnished is physically present in the critical access hospital, or in a skilled nursing facility or a clinic (including a rural health clinic) that is operated by a critical access hospital, at the time the specimen is collected.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after July 1, 2009.

SEC. 149. ADDING CERTAIN ENTITIES AS ORIGINATING SITES FOR PAYMENT OF TELEHEALTH SERVICES.

(a) IN GENERAL.—Section 1834(m)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subclauses:

"(VI) A hospital-based or critical access hospital-based renal dialysis center (including satellites).

"(VII) A skilled nursing facility (as defined in section 1819(a)).

"(VIII) A community mental health center (as defined in section 1861(ff)(3)(B)).".

(b) CONFORMING AMENDMENT.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting "telehealth services furnished under section 1834(m)(4)(C)(ii)(VII)," after "section 1861(s)(2),".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2009.

SEC. 150. MEDPAC STUDY AND REPORT ON IMPROVING CHRONIC CARE DEMONSTRATION PROGRAMS.

(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the "Commission") shall conduct a study on the feasability and advisability of establishing a Medicare Chronic Care Practice Research Network that would serve as a standing network of providers testing new models of care coordination and other care approaches for chronically ill beneficiaries, including the initiation, operation, evaluation, and, if appropriate, expansion of such models to the broader Medicare patient

population. In conducting such study, the Commission shall take into account the structure, implementation, and results of prior and existing care coordination and disease management demonstrations and pilots, including the Medicare Coordinated Care Demonstration Project under section 4016 of the Balanced Budget Act of 1997 (42 U.S.C. 1395b–1 note) and the chronic care improvement programs under section 1807 of the Social Security Act (42 U.S.C. 1395b–8), commonly known to as "Medicare Health Support".

(b) REPORT.—Not later than June 15, 2009, the Commission shall submit to Congress a report containing the results of the study conducted under subsection (a).

SEC. 151. INCREASE OF FQHC PAYMENT LIMITS.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

"(v) INCREASE OF FQHC PAYMENT LIMITS.—In the case of services furnished by federally qualified health centers (as defined in section 1861(aa)(4)), the Secretary shall establish payment limits with respect to such services under this part for services furnished—

"(1) in 2010, at the limits otherwise established under this part for such year increased by $5; and

"(2) in a subsequent year, at the limits established under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year.".

(b) STUDY AND REPORT ON THE EFFECTS AND ADEQUACY OF THE MEDICARE FEDERALLY QUALIFIED HEALTH CENTER PAYMENT STRUCTURE.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine whether the structure for payments for services furnished by federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4)) under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) adequately reimburses federally qualified health centers for the care furnished to Medicare beneficiaries. In conducting such study, the Comptroller General shall—

(A) use the most current cost report data available;

(B) examine the effects of the payment limits established with respect to such services under such part B on the ability of federally

qualified health centers to furnish care to Medicare beneficiaries; and

(C) examine the cost of furnishing services covered under the Medicare program as of the date of the enactment of this Act that were not covered under such program as of the date on which the Secretary determined the payment rate for federally qualified health centers in 1991.

(2) REPORT.—Not later than 15 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action the Comptroller General determines appropriate, taking into consideration the structure and adequacy of the prospective payment methodology used to make payments to federally qualified health centers under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

SEC. 152. KIDNEY DISEASE EDUCATION AND AWARENESS PROVISIONS.

(a) CHRONIC KIDNEY DISEASE INITIATIVES.—Part P of title III of the Public Health Service Act (42 U.S.C.

280g et seq.) is amended by adding at the end the following new section:

"SEC. 399R. CHRONIC KIDNEY DISEASE INITIATIVES.

"(a) IN GENERAL.—The Secretary shall establish pilot projects to—

"(1) increase public and medical community awareness (particularly of those who treat patients with diabetes and hypertension) regarding chronic kidney disease, focusing on prevention;

"(2) increase screening for chronic kidney disease, focusing on Medicare beneficiaries at risk of chronic kidney disease; and

"(3) enhance surveillance systems to better assess the prevalence and incidence of chronic kidney disease.

"(b) SCOPE AND DURATION.—

"(1) SCOPE.—The Secretary shall select at least 3 States in which to conduct pilot projects under this section.

"(2) DURATION.—The pilot projects under this section shall be conducted for a period that is not longer than 5 years and shall begin on January 1, 2009.

"(c) EVALUATION AND REPORT.—The Comptroller General of the United States shall conduct an evaluation

of the pilot projects conducted under this section. Not later than 12 months after the date on which the pilot projects are completed, the Comptroller General shall submit to Congress a report on the evaluation.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for the purpose of carrying out this section.".

(b) MEDICARE COVERAGE OF KIDNEY DISEASE PATIENT EDUCATION SERVICES.—

(1) COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.—

(A) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 144(a), is amended—

(i) in subparagraph (CC), by striking "and" after the semicolon at the end;

(ii) in subparagraph (DD), by adding "and" after the semicolon at the end; and

(iii) by adding at the end the following new subparagraph:

"(EE) kidney disease education services (as defined in subsection (ggg));".

(B) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x),

as amended by section 144(a), is amended by adding at the end the following new subsection:

"Kidney Disease Education Services

"(ggg)(1) The term 'kidney disease education services' means educational services that are—

"(A) furnished to an individual with stage IV chronic kidney disease who, according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant;

"(B) furnished, upon the referral of the physician managing the individual's kidney condition, by a qualified person (as defined in paragraph (2)); and

"(C) designed—

"(i) to provide comprehensive information (consistent with the standards set under paragraph (3)) regarding—

"(I) the management of comorbidities, including for purposes of delaying the need for dialysis;

"(II) the prevention of uremic complications; and

"(III) each option for renal replacement therapy (including hemodialysis and peritoneal dialysis at home and in-center

as well as vascular access options and transplantation);

"(ii) to ensure that the individual has the opportunity to actively participate in the choice of therapy; and

"(iii) to be tailored to meet the needs of the individual involved.

"(2)(A) The term 'qualified person' means—

"(i) a physician (as defined in section 1861(r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5)), who furnishes services for which payment may be made under the fee schedule established under section 1848; and

"(ii) a provider of services located in a rural area (as defined in section 1886(d)(2)(D)).

"(B) Such term does not include a provider of services (other than a provider of services described in subparagraph (A)(ii)) or a renal dialysis facility.

"(3) The Secretary shall set standards for the content of such information to be provided under paragraph (1)(C)(i) after consulting with physicians, other health professionals, health educators, professional organizations, accrediting organizations, kidney patient organizations, dialysis facilities, transplant centers, network organizations

described in section 1881(c)(2), and other knowledgeable persons. To the extent possible the Secretary shall consult with persons or entities described in the previous sentence, other than a dialysis facility, that has not received industry funding from a drug or biological manufacturer or dialysis facility.

"(4) No individual shall be furnished more than 6 sessions of kidney disease education services under this title.".

(C) PAYMENT UNDER THE PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)), as amended by section 144(b), is amended by inserting "(2)(EE)," after "(2)(DD),".

(D) LIMITATION ON NUMBER OF SESSIONS.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(i) in subparagraph (M), by striking "and" at the end;

(ii) in subparagraph (N), by striking the semicolon at the end and inserting ", and"; and

(iii) by adding at the end the following new subparagraph:

"(O) in the case of kidney disease education services (as defined in paragraph (1) of section 1861(ggg)), which are furnished in excess of the number of sessions covered under paragraph (4) of such section;".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2010.

SEC. 153. RENAL DIALYSIS PROVISIONS.

(a) COMPOSITE RATE.—

(1) UPDATE.—Section 1881(b)(12)(G) of the Social Security Act (42 U.S.C. 1395rr(b)(12)(G)) is amended—

(A) in clause (i), by striking "and" at the end;

(B) in clause (ii)—

(i) by inserting "and before January 1, 2009," after "April 1, 2007,"; and

(ii) by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following new clauses:

"(iii) furnished on or after January 1, 2009, and before January 1, 2010, by 1.0 percent above

the amount of such composite rate component for such services furnished on December 31, 2008; and

"(iv) furnished on or after January 1, 2010, by 1.0 percent above the amount of such composite rate component for such services furnished on December 31, 2009.".

(2) SITE NEUTRAL COMPOSITE RATE.—Section 1881(b)(12)(A) of the Social Security Act (42 U.S.C. 1395rr(b)(12)(A)) is amended by adding at the end the following new sentence: "Under such system, the payment rate for dialysis services furnished on or after January 1, 2009, by providers of services shall be the same as the payment rate (computed without regard to this sentence) for such services furnished by renal dialysis facilities, and in applying the geographic index under subparagraph (D) to providers of services, the labor share shall be based on the labor share otherwise applied for renal dialysis facilities.".

(b) DEVELOPMENT OF ESRD BUNDLED PAYMENT SYSTEM.—

(1) IN GENERAL.—Section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)) is amended by adding at the end the following new paragraph:

"(14)(A)(i) Subject to subparagraph (E), for services furnished on or after January 1, 2011, the Secretary shall implement a payment system under which a single payment is made under this title to a provider of services or a renal dialysis facility for renal dialysis services (as defined in subparagraph (B)) in lieu of any other payment (including a payment adjustment under paragraph (12)(B)(ii)) and for such services and items furnished pursuant to paragraph (4).

"(ii) In implementing the system under this paragraph the Secretary shall ensure that the estimated total amount of payments under this title for 2011 for renal dialysis services shall equal 98 percent of the estimated total amount of payments for renal dialysis services, including payments under paragraph (12)(B)(ii), that would have been made under this title with respect to services furnished in 2011 if such system had not been implemented. In making the estimation under subclause (I), the Secretary shall use per patient utilization data from 2007, 2008, or 2009, whichever has the lowest per patient utilization.

"(B) For purposes of this paragraph, the term 'renal dialysis services' includes—

"(i) items and services included in the composite rate for renal dialysis services as of December 31, 2010;

"(ii) erythropoiesis stimulating agents and any oral form of such agents that are furnished to individuals for the treatment of end stage renal disease;

"(iii) other drugs and biologicals that are furnished to individuals for the treatment of end stage renal disease and for which payment was (before the application of this paragraph) made separately under this title, and any oral equivalent form of such drug or biological; and

"(iv) diagnostic laboratory tests and other items and services not described in clause (i) that are furnished to individuals for the treatment of end stage renal disease.

Such term does not include vaccines.

"(C) The system under this paragraph may provide for payment on the basis of services furnished during a week or month or such other appropriate unit of payment as the Secretary specifies.

"(D) Such system—

"(i) shall include a payment adjustment based on case mix that may take into account patient weight, body mass index, comorbidities, length of

time on dialysis, age, race, ethnicity, and other appropriate factors;

"(ii) shall include a payment adjustment for high cost outliers due to unusual variations in the type or amount of medically necessary care, including variations in the amount of erythropoiesis stimulating agents necessary for anemia management;

"(iii) shall include a payment adjustment that reflects the extent to which costs incurred by low-volume facilities (as defined by the Secretary) in furnishing renal dialysis services exceed the costs incurred by other facilities in furnishing such services, and for payment for renal dialysis services furnished on or after January 1, 2011, and before January 1, 2014, such payment adjustment shall not be less than 10 percent; and

"(iv) may include such other payment adjustments as the Secretary determines appropriate, such as a payment adjustment—

"(I) for pediatric providers of services and renal dialysis facilities;

"(II) by a geographic index, such as the index referred to in paragraph (12)(D), as the Secretary determines to be appropriate; and

"(III) for providers of services or renal dialysis facilities located in rural areas.

The Secretary shall take into consideration the unique treatment needs of children and young adults in establishing such system.

"(E)(i) The Secretary shall provide for a four-year phase-in (in equal increments) of the payment amount under the payment system under this paragraph, with such payment amount being fully implemented for renal dialysis services furnished on or after January 1, 2014.

"(ii) A provider of services or renal dialysis facility may make a one-time election to be excluded from the phase-in under clause (i) and be paid entirely based on the payment amount under the payment system under this paragraph. Such an election shall be made prior to January 1, 2011, in a form and manner specified by the Secretary, and is final and may not be rescinded.

"(iii) The Secretary shall make an adjustment to the payments under this paragraph for years during which the phase-in under clause (i) is applicable so that the estimated total amount of payments under this paragraph, including payments under this subparagraph, shall equal the estimated total amount of payments that would otherwise occur under this paragraph without such phase-in.

"(F)(i) Subject to clause (ii), beginning in 2012, the Secretary shall annually increase payment amounts established under this paragraph by an ESRD market basket percentage increase factor for a bundled payment system for renal dialysis services that reflects changes over time in the prices of an appropriate mix of goods and services included in renal dialysis services minus 1.0 percentage point.

"(ii) For years during which a phase-in of the payment system pursuant to subparagraph (E) is applicable, the following rules shall apply to the portion of the payment under the system that is based on the payment of the composite rate that would otherwise apply if the system under this paragraph had not been enacted:

"(I) The update under clause (i) shall not apply.

"(II) The Secretary shall annually increase such composite rate by the ESRD market basket percentage increase factor described in clause (i) minus 1.0 percentage point.

"(G) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the determination of payment amounts under subparagraph (A), the establishment of an appropriate unit of payment under subparagraph (C), the identification of renal dialy-

sis services included in the bundled payment, the adjustments under subparagraph (D), the application of the phase-in under subparagraph (E), and the establishment of the market basket percentage increase factors under subparagraph (F).

"(H) Erythropoiesis stimulating agents and other drugs and biologicals shall be treated as prescribed and dispensed or administered and available only under part B if they are—

"(i) furnished to an individual for the treatment of end stage renal disease; and

"(ii) included in subparagraph (B) for purposes of payment under this paragraph.".

(2) PROHIBITION OF UNBUNDLING.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)), as amended by section 135(a)(2), is amended—

(A) in paragraph (22), by striking "or" at the end;

(B) in paragraph (23), by striking the period at the end and inserting "; or"; and

(C) by inserting after paragraph (23) the following new paragraph:

"(24) where such expenses are for renal dialysis services (as defined in subparagraph (B) of section

1881(b)(14)) for which payment is made under such section unless such payment is made under such section to a provider of services or a renal dialysis facility for such services.".

(3) CONFORMING AMENDMENTS.—(A) Section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)) is amended—

(i) in paragraph (12)(A), by striking "In lieu of payment" and inserting "Subject to paragraph (14), in lieu of payment";

(ii) in the second sentence of paragraph (12)(F)—

(I) by inserting "or paragraph (14)" after "this paragraph"; and

(II) by inserting "or under the system under paragraph (14)" after "subparagraph (B)"; and

(iii) in paragraph (13)—

(I) in subparagraph (A), in the matter preceding clause (i), by striking "The payment amounts" and inserting "Subject to paragraph (14), the payment amounts"; and

(II) in subparagraph (B)—

(aa) in clause (i), by striking "(i)" after "(B)" and by inserting ", subject to paragraph (14)" before the period at the end; and

(bb) by striking clause (ii).

(B) Section 1861(s)(2)(F) of the Social Security Act (42 U.S.C. 1395x(s)(2)(F)) is amended by inserting ", and, for items and services furnished on or after January 1, 2011, renal dialysis services (as defined in section 1881(b)(14)(B))" before the semicolon at the end.

(C) Section 623(e) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395rr note) is repealed.

(4) RULE OF CONSTRUCTION.—Nothing in this subsection or the amendments made by this subsection shall be construed as authorizing or requiring the Secretary of Health and Human Services to make payments under the payment system implemented under paragraph (14)(A)(i) of section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)), as added by paragraph (1), for any unrecovered amount for any bad debt attributable to deductible and coinsurance on items and services not included in the basic case-mix adjusted composite

rate under paragraph (12) of such section as in effect before the date of the enactment of this Act.

(c) QUALITY INCENTIVES IN THE END-STAGE RENAL DISEASE PROGRAM.—Section 1881 of the Social Security Act (42 U.S.C. 1395rr) is amended by adding at the end the following new subsection:

"(h) QUALITY INCENTIVES IN THE END-STAGE RENAL DISEASE PROGRAM.—

"(1) QUALITY INCENTIVES.—

"(A) IN GENERAL.—With respect to renal dialysis services (as defined in subsection (b)(14)(B)) furnished on or after January 1, 2012, in the case of a provider of services or a renal dialysis facility that does not meet the requirement described in subparagraph (B) with respect to the year, payments otherwise made to such provider or facility under the system under subsection (b)(14) for such services shall be reduced by up to 2.0 percent, as determined appropriate by the Secretary.

"(B) REQUIREMENT.—The requirement described in this subparagraph is that the provider or facility meets (or exceeds) the total performance score under paragraph (3) with respect to performance standards established by

the Secretary with respect to measures specified in paragraph (2).

"(C) NO EFFECT IN SUBSEQUENT YEARS.—The reduction under subparagraph (A) shall apply only with respect to the year involved, and the Secretary shall not take into account such reduction in computing the single payment amount under the system under paragraph (14) in a subsequent year.

"(2) MEASURES.—

"(A) IN GENERAL.—The measures specified under this paragraph with respect to the year involved shall include—

"(i) measures on anemia management that reflect the labeling approved by the Food and Drug Administration for such management and measures on dialysis adequacy;

"(ii) to the extent feasible, such measure (or measures) of patient satisfaction as the Secretary shall specify; and

"(iii) such other measures as the Secretary specifies, including, to the extent feasible, measures on—

"(I) iron management;

"(II) bone mineral metabolism; and

"(III) vascular access, including for maximizing the placement of arterial venous fistula.

"(B) USE OF ENDORSED MEASURES.—

"(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under subparagraph (A)(iii) must have been endorsed by the entity with a contract under section 1890(a).

"(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

"(C) UPDATING MEASURES.—The Secretary shall establish a process for updating the

measures specified under subparagraph (A) in consultation with interested parties.

"(D) CONSIDERATION.—In specifying measures under subparagraph (A), the Secretary shall consider the availability of measures that address the unique treatment needs of children and young adults with kidney failure.

"(3) PERFORMANCE SCORES.—

"(A) TOTAL PERFORMANCE SCORE.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary shall develop a methodology for assessing the total performance of each provider of services and renal dialysis facility based on performance standards with respect to the measures selected under paragraph (2) for a performance period established under paragraph (4)(D) (in this subsection referred to as the 'total performance score').

"(ii) APPLICATION.—For providers of services and renal dialysis facilities that do not meet (or exceed) the total performance score established by the Secretary, the Secretary shall ensure that the application of the methodology developed under clause (i)

results in an appropriate distribution of reductions in payment under paragraph (1) among providers and facilities achieving different levels of total performance scores, with providers and facilities achieving the lowest total performance scores receiving the largest reduction in payment under paragraph (1)(A).

"(iii) WEIGHTING OF MEASURES.—In calculating the total performance score, the Secretary shall weight the scores with respect to individual measures calculated under subparagraph (B) to reflect priorities for quality improvement, such as weighting scores to ensure that providers of services and renal dialysis facilities have strong incentives to meet or exceed anemia management and dialysis adequacy performance standards, as determined appropriate by the Secretary.

"(B) PERFORMANCE SCORE WITH RESPECT TO INDIVIDUAL MEASURES.—The Secretary shall also calculate separate performance scores for each measure, including for dialysis adequacy and anemia management.

"(4) PERFORMANCE STANDARDS.—

"(A) ESTABLISHMENT.—Subject to subparagraph (E), the Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period with respect to a year (as established under subparagraph (D)).

"(B) ACHIEVEMENT AND IMPROVEMENT.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement, as determined appropriate by the Secretary.

"(C) TIMING.—The Secretary shall establish the performance standards under subparagraph (A) prior to the beginning of the performance period for the year involved.

"(D) PERFORMANCE PERIOD.—The Secretary shall establish the performance period with respect to a year. Such performance period shall occur prior to the beginning of such year.

"(E) SPECIAL RULE.—The Secretary shall initially use as the performance standard for the measures specified under paragraph (2)(A)(i) for a provider of services or a renal dialysis facility the lesser of—

"(i) the performance of such provider or facility for such measures in the year selected by the Secretary under the second sentence of subsection (b)(14)(A)(ii); or

"(ii) a performance standard based on the national performance rates for such measures in a period determined by the Secretary.

"(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(A) The determination of the amount of the payment reduction under paragraph (1).

"(B) The establishment of the performance standards and the performance period under paragraph (4).

"(C) The specification of measures under paragraph (2).

"(D) The methodology developed under paragraph (3) that is used to calculate total performance scores and performance scores for individual measures.

"(6) PUBLIC REPORTING.—

"(A) IN GENERAL.—The Secretary shall establish procedures for making information re-

garding performance under this subsection available to the public, including—

"(i) the total performance score achieved by the provider of services or renal dialysis facility under paragraph (3) and appropriate comparisons of providers of services and renal dialysis facilities to the national average with respect to such scores; and

"(ii) the performance score achieved by the provider or facility with respect to individual measures.

"(B) OPPORTUNITY TO REVIEW.—The procedures established under subparagraph (A) shall ensure that a provider of services and a renal dialysis facility has the opportunity to review the information that is to be made public with respect to the provider or facility prior to such data being made public.

"(C) CERTIFICATES.—

"(i) IN GENERAL.—The Secretary shall provide certificates to providers of services and renal dialysis facilities who furnish renal dialysis services under this section to display in patient areas. The

certificate shall indicate the total performance score achieved by the provider or facility under paragraph (3).

"(ii) DISPLAY.—Each facility or provider receiving a certificate under clause (i) shall prominently display the certificate at the provider or facility.

"(D) WEB-BASED LIST.—The Secretary shall establish a list of providers of services and renal dialysis facilities who furnish renal dialysis services under this section that indicates the total performance score and the performance score for individual measures achieved by the provider and facility under paragraph (3). Such information shall be posted on the Internet website of the Centers for Medicare & Medicaid Services in an easily understandable format.".

(d) GAO REPORT ON ESRD BUNDLING SYSTEM AND QUALITY INITIATIVE.—Not later than March 1, 2013, the Comptroller General of the United States shall submit to Congress a report on the implementation of the payment system under subsection (b)(14) of section 1881 of the Social Security Act (as added by subsection (b)) for renal dialysis services and related services (defined in subparagraph (B) of such subsection (b)(14)) and the quality ini-

tiative under subsection (h) of such section 1881 (as added by subsection (b)). Such report shall include the following information:

(1) The changes in utilization rates for erythropoiesis stimulating agents.

(2) The mode of administering such agents, including information on the proportion of individuals receiving such agents intravenously as compared to subcutaneously.

(3) An analysis of the payment adjustment under subparagraph (D)(iii) of such subsection (b)(14), including an examination of the extent to which costs incurred by rural, low-volume providers and facilities (as defined by the Secretary) in furnishing renal dialysis services exceed the costs incurred by other providers and facilities in furnishing such services, and a recommendation regarding the appropriateness of such adjustment.

(4) The changes, if any, in utilization rates of drugs and biologicals that the Secretary identifies under subparagraph (B)(iii) of such subsection (b)(14), and any oral equivalent or oral substitutable forms of such drugs and biologicals or of drugs and biologicals described in clause (ii), that have oc-

curred after implementation of the payment system under such subsection (b)(14).

(5) Any other information or recommendations for legislative and administrative actions determined appropriate by the Comptroller General.

SEC. 154. DELAY IN AND REFORM OF MEDICARE DMEPOS COMPETITIVE ACQUISITION PROGRAM.

(a) TEMPORARY DELAY AND REFORM.—

(1) IN GENERAL.—Section 1847(a)(1) of the Social Security Act (42 U.S.C. 1395w–3(a)(1)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (B)(i), in the matter before subclause (I), by inserting "consistent with subparagraph (D)" after "in a manner";

(ii) in subparagraph (B)(i)(II), by striking "80" and "in 2009" and inserting "an additional 70" and "in 2011", respectively;

(iii) in subparagraph (B)(i)(III), by striking "after 2009" and inserting "after 2011 (or, in the case of national mail order for items and services, after 2010)"; and

(iv) by adding at the end the following new subparagraphs:

"(D) CHANGES IN COMPETITIVE ACQUISITION PROGRAMS.—

"(i) ROUND 1 OF COMPETITIVE ACQUISITION PROGRAM.—Notwithstanding subparagraph (B)(i)(I) and in implementing the first round of the competitive acquisition programs under this section—

"(I) the contracts awarded under this section before the date of the enactment of this subparagraph are terminated, no payment shall be made under this title on or after the date of the enactment of this subparagraph based on such a contract, and, to the extent that any damages may be applicable as a result of the termination of such contracts, such damages shall be payable from the Federal Supplementary Medical Insurance Trust Fund under section 1841;

"(II) the Secretary shall conduct the competition for such round in a manner so that it occurs in 2009 with

respect to the same items and services and the same areas, except as provided in subclauses (III) and (IV);

"(III) the Secretary shall exclude Puerto Rico so that such round of competition covers 9, instead of 10, of the largest metropolitan statistical areas; and

"(IV) there shall be excluded negative pressure wound therapy items and services.

Nothing in subclause (I) shall be construed to provide an independent cause of action or right to administrative or judicial review with regard to the termination provided under such subclause.

"(ii) ROUND 2 OF COMPETITIVE ACQUISITION PROGRAM.—In implementing the second round of the competitive acquisition programs under this section described in subparagraph (B)(i)(II)—

"(I) the metropolitan statistical areas to be included shall be those metropolitan statistical areas selected

by the Secretary for such round as of June 1, 2008; and

"(II) the Secretary may subdivide metropolitan statistical areas with populations (based upon the most recent data from the Census Bureau) of at least 8,000,000 into separate areas for competitive acquisition purposes.

"(iii) EXCLUSION OF CERTAIN AREAS IN SUBSEQUENT ROUNDS OF COMPETITIVE ACQUISITION PROGRAMS.—In implementing subsequent rounds of the competitive acquisition programs under this section, including under subparagraph (B)(i)(III), for competitions occurring before 2015, the Secretary shall exempt from the competitive acquisition program (other than national mail order) the following:

"(I) Rural areas.

"(II) Metropolitan statistical areas not selected under round 1 or round 2 with a population of less than 250,000.

"(III) Areas with a low population density within a metropolitan statistical area that is otherwise selected, as determined for purposes of paragraph (3)(A).

"(E) VERIFICATION BY OIG.—The Inspector General of the Department of Health and Human Services shall, through post-award audit, survey, or otherwise, assess the process used by the Centers for Medicare & Medicaid Services to conduct competitive bidding and subsequent pricing determinations under this section that are the basis for pivotal bid amounts and single payment amounts for items and services in competitive bidding areas under rounds 1 and 2 of the competitive acquisition programs under this section and may continue to verify such calculations for subsequent rounds of such programs.

"(F) SUPPLIER FEEDBACK ON MISSING FINANCIAL DOCUMENTATION.—

"(i) IN GENERAL.—In the case of a bid where one or more covered documents in connection with such bid have been submitted not later than the covered document

review date specified in clause (ii), the Secretary—

"(I) shall provide, by not later than 45 days (in the case of the first round of the competitive acquisition programs as described in subparagraph (B)(i)(I)) or 90 days (in the case of a subsequent round of such programs) after the covered document review date, for notice to the bidder of all such documents that are missing as of the covered document review date; and

"(II) may not reject the bid on the basis that any covered document is missing or has not been submitted on a timely basis, if all such missing documents identified in the notice provided to the bidder under subclause (I) are submitted to the Secretary not later than 10 business days after the date of such notice.

"(ii) COVERED DOCUMENT REVIEW DATE.—The covered document review date specified in this clause with respect to a

competitive acquisition program is the later of—

"(I) the date that is 30 days before the final date specified by the Secretary for submission of bids under such program; or

"(II) the date that is 30 days after the first date specified by the Secretary for submission of bids under such program.

"(iii) LIMITATIONS OF PROCESS.—The process provided under this subparagraph—

"(I) applies only to the timely submission of covered documents;

"(II) does not apply to any determination as to the accuracy or completeness of covered documents submitted or whether such documents meet applicable requirements;

"(III) shall not prevent the Secretary from rejecting a bid based on any basis not described in clause (i)(II); and

"(IV) shall not be construed as permitting a bidder to change bidding amounts or to make other changes in a bid submission.

"(iv) COVERED DOCUMENT DEFINED.—In this subparagraph, the term 'covered document' means a financial, tax, or other document required to be submitted by a bidder as part of an original bid submission under a competitive acquisition program in order to meet required financial standards. Such term does not include other documents, such as the bid itself or accreditation documentation."; and

(B) in paragraph (2)(A), by inserting before the period at the end the following: "and excluding certain complex rehabilitative power wheelchairs recognized by the Secretary as classified within group 3 or higher (and related accessories when furnished in connection with such wheelchairs)".

(2) BUDGET NEUTRAL OFFSET.—

(A) IN GENERAL.—Section 1834(a)(14) of such Act (42 U.S.C. 1395m(a)(14)) is amended—

(i) by striking "and" at the end of subparagraphs (H) and (I);

(ii) by redesignating subparagraph (J) as subparagraph (M); and

(iii) by inserting after subparagraph (I) the following new subparagraphs:

"(J) for 2009—

"(i) in the case of items and services furnished in any geographic area, if such items or services were selected for competitive acquisition in any area under the competitive acquisition program under section 1847(a)(1)(B)(i)(I) before July 1, 2008, including related accessories but only if furnished with such items and services selected for such competition and diabetic supplies but only if furnished through mail order, −9.5 percent; or

"(ii) in the case of other items and services, the percentage increase in the consumer price index for all urban con-

sumers (U.S. urban average) for the 12-month period ending with June 2008;

"(K) for 2010, 2011, 2012, and 2013, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year;

"(L) for 2014—

"(i) in the case of items and services described in subparagraph (J)(i) for which a payment adjustment has not been made under subsection (a)(1)(F)(ii) in any previous year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June 2013, plus 2.0 percentage points; or

"(ii) in the case of other items and services, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June 2013; and".

(B) CONFORMING TREATMENT FOR CERTAIN ITEMS AND SERVICES.—The second sen-

tence of section 1842(s)(1) of such Act (42 U.S.C. 1395u(s)(1)) is amended by striking "except that" and all that follows and inserting the following: "except that for items and services described in paragraph (2)(D)—

"(A) for 2009 section 1834(a)(14)(J)(i) shall apply under this paragraph instead of the percentage increase otherwise applicable; and

"(B) for 2014, if subparagraph (A) is applied to the items and services and there has not been a payment adjustment under paragraph (3)(B) for the items and services for any previous year, the percentage increase computed under section 1834(a)(14)(L)(i) shall apply instead of the percentage increase otherwise applicable.".

(3) CONFORMING DELAY.—Subsections (a)(1)(F) and (h)(1)(H) of section 1834 of the Social Security Act (42 U.S.C. 1395m) are each amended by striking "January 1, 2009" and inserting "January 1, 2011".

(4) CONSIDERATIONS IN APPLICATION.—Section 1834 of such Act (42 U.S.C. 1395m) is amended—

(A) in subsection (a)(1)—

(i) in subparagraph (F), by inserting "subject to subparagraph (G)," before "that are included"; and

(ii) by adding at the end the following new subparagraph:

"(G) USE OF INFORMATION ON COMPETITIVE BID RATES.—The Secretary shall specify by regulation the methodology to be used in applying the provisions of subparagraph (F)(ii) and subsection (h)(1)(H)(ii). In promulgating such regulation, the Secretary shall consider the costs of items and services in areas in which such provisions would be applied compared to the payment rates for such items and services in competitive acquisition areas."; and

(B) in subsection (h)(1)(H), by inserting "subject to subsection (a)(1)(G)," before "that are included".

(b) QUALITY STANDARDS.—

(1) APPLICATION OF ACCREDITATION REQUIREMENT.—

(A) IN GENERAL.—Section 1834(a)(20) of the Social Security Act (42 U.S.C. 1395m(a)(20)) is amended—

(i) in subparagraph (E), by inserting "including subparagraph (F)," after "under this paragraph,"; and

(ii) by adding at the end the following new subparagraph:

"(F) APPLICATION OF ACCREDITATION REQUIREMENT.—In implementing quality standards under this paragraph—

"(i) subject to clause (ii), the Secretary shall require suppliers furnishing items and services described in subparagraph (D) on or after October 1, 2009, directly or as a subcontractor for another entity, to have submitted to the Secretary evidence of accreditation by an accreditation organization designated under subparagraph (B) as meeting applicable quality standards; and

"(ii) in applying such standards and the accreditation requirement of clause (i) with respect to eligible professionals (as defined in section 1848(k)(3)(B)), and including such other persons, such as orthotists and prosthetists, as specified by

the Secretary, furnishing such items and services—

"(I) such standards and accreditation requirement shall not apply to such professionals and persons unless the Secretary determines that the standards being applied are designed specifically to be applied to such professionals and persons; and

"(II) the Secretary may exempt such professionals and persons from such standards and requirement if the Secretary determines that licensing, accreditation, or other mandatory quality requirements apply to such professionals and persons with respect to the furnishing of such items and services.".

(B) CONSTRUCTION.—Section 1834(a)(20)(F)(ii) of the Social Security Act, as added by subparagraph (A), shall not be construed as preventing the Secretary of Health and Human Services from implementing the first round of competition under section 1847 of such Act on a timely basis.

(2) DISCLOSURE OF SUBCONTRACTORS UNDER COMPETITIVE ACQUISITION PROGRAM.—Section 1847(b)(3) of such Act (42 U.S.C. 1395w–3(b)(3)) is amended by adding at the end the following new subparagraph:

"(C) DISCLOSURE OF SUBCONTRACTORS.—

"(i) INITIAL DISCLOSURE.—Not later than 10 days after the date a supplier enters into a contract with the Secretary under this section, such supplier shall disclose to the Secretary, in a form and manner specified by the Secretary, the information on—

"(I) each subcontracting relationship that such supplier has in furnishing items and services under the contract; and

"(II) whether each such subcontractor meets the requirement of section 1834(a)(20)(F)(i), if applicable to such subcontractor.

"(ii) SUBSEQUENT DISCLOSURE.—Not later than 10 days after such a supplier subsequently enters into a subcontracting

relationship described in clause (i)(II), such supplier shall disclose to the Secretary, in such form and manner, the information described in subclauses (I) and (II) of clause (i).".

(3) COMPETITIVE ACQUISITION OMBUDSMAN.—Such section is further amended by adding at the end the following new subsection:

"(f) COMPETITIVE ACQUISITION OMBUDSMAN.—The Secretary shall provide for a competitive acquisition ombudsman within the Centers for Medicare & Medicaid Services in order to respond to complaints and inquiries made by suppliers and individuals relating to the application of the competitive acquisition program under this section. The ombudsman may be within the office of the Medicare Beneficiary Ombudsman appointed under section 1808(c). The ombudsman shall submit to Congress an annual report on the activities under this subsection, which report shall be coordinated with the report provided under section 1808(c)(2)(C).".

(c) CHANGE IN REPORTS AND DEADLINES.—

(1) GAO REPORT.—Section 302(b)(3) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is amended—

(A) in subparagraph (A)—

(i) by inserting "and as amended by section 2 of the Medicare DMEPOS Competitive Acquisition Reform Act of 2008" after "as amended by paragraph (1)"; and

(ii) by inserting before the period at the end the following: "and the topics specified in subparagraph (C)";

(B) in subparagraph (B), by striking "Not later than January 1, 2009," and inserting "Not later than 1 year after the first date that payments are made under section 1847 of the Social Security Act,"; and

(C) by adding at the end the following new subparagraph:

"(C) TOPICS.—The topics specified in this subparagraph, for the study under subparagraph (A) concerning the competitive acquisition program, are the following:

"(i) Beneficiary access to items and services under the program, including the impact on such access of awarding contracts to bidders that—

"(I) did not have a physical presence in an area where they received a contract; or

"(II) had no previous experience providing the product category they were contracted to provide.

"(ii) Beneficiary satisfaction with the program and cost savings to beneficiaries under the program.

"(iii) Costs to suppliers of participating in the program and recommendations about ways to reduce those costs without compromising quality standards or savings to the Medicare program.

"(iv) Impact of the program on small business suppliers.

"(v) Analysis of the impact on utilization of different items and services paid within the same Healthcare Common Procedure Coding System (HCPCS) code.

"(vi) Costs to the Centers for Medicare & Medicaid Services, including payments made to contractors, for administering the program compared with administration of a fee schedule, in compari-

son with the relative savings of the program.

"(vii) Impact on access, Medicare spending, and beneficiary spending of any difference in treatment for diabetic testing supplies depending on how such supplies are furnished.

"(viii) Such other topics as the Comptroller General determines to be appropriate.".

(2) DELAY IN OTHER DEADLINES.—

(A) PROGRAM ADVISORY AND OVERSIGHT COMMITTEE.—Section 1847(c)(5) of the Social Security Act (42 U.S.C. 1395w–3(c)(5)) is amended by striking "December 31, 2009" and inserting "December 31, 2011".

(B) SECRETARIAL REPORT.—Section 1847(d) of such Act (42 U.S.C. 1395w–3(d)) is amended by striking "July 1, 2009" and inserting "July 1, 2011".

(C) IG REPORT.—Section 302(e) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is amended by striking "July 1, 2009" and inserting "July 1, 2011".

(3) EVALUATION OF CERTAIN CODE.—The Secretary of Health and Human Services shall evaluate the existing Health Care Common Procedure Coding System (HCPCS) codes for negative pressure wound therapy to ensure accurate reporting and billing for items and services under such codes. In carrying out such evaluation, the Secretary shall use an existing process, administered by the Durable Medical Equipment Medicare Administrative Contractors, for the consideration of coding changes and consider all relevant studies and information furnished pursuant to such process.

(d) OTHER PROVISIONS.—

(1) EXEMPTION FROM COMPETITIVE ACQUISITION FOR CERTAIN OFF-THE-SHELF ORTHOTICS.—Section 1847(a) of the Social Security Act (42 U.S.C. 1395w–3(a)) is amended by adding at the end the following new paragraph:

"(7) EXEMPTION FROM COMPETITIVE ACQUISITION.—The programs under this section shall not apply to the following:

"(A) CERTAIN OFF-THE-SHELF ORTHOTICS.—Items and services described in paragraph (2)(C) if furnished—

"(i) by a physician or other practitioner (as defined by the Secretary) to the physician's or practitioner's own patients as part of the physician's or practitioner's professional service; or

"(ii) by a hospital to the hospital's own patients during an admission or on the date of discharge.

"(B) CERTAIN DURABLE MEDICAL EQUIPMENT.—Those items and services described in paragraph (2)(A)—

"(i) that are furnished by a hospital to the hospital's own patients during an admission or on the date of discharge; and

"(ii) to which such programs would not apply, as specified by the Secretary, if furnished by a physician to the physician's own patients as part of the physician's professional service.".

(2) CORRECTION IN FACE-TO-FACE EXAMINATION REQUIREMENT.—Section 1834(a)(1)(E)(ii) of such Act (42 U.S.C. 1395m(a)(1)(E)(ii)) is amended by striking "1861(r)(1)" and inserting "1861(r)".

(3) SPECIAL RULE IN CASE OF NATIONAL MAIL-ORDER COMPETITION FOR DIABETIC TESTING

STRIPS.—Section 1847(b) of such Act (42 U.S.C. 1395w–3(b)) is amended—

(A) by redesignating paragraph (10) as paragraph (11); and

(B) by inserting after paragraph (9) the following new paragraph:

"(10) SPECIAL RULE IN CASE OF COMPETITION FOR DIABETIC TESTING STRIPS.—

"(A) IN GENERAL.—With respect to the competitive acquisition program for diabetic testing strips conducted after the first round of the competitive acquisition programs, if an entity does not demonstrate to the Secretary that its bid covers types of diabetic testing strip products that, in the aggregate and taking into account volume for the different products, cover 50 percent (or such higher percentage as the Secretary may specify) of all such types of products, the Secretary shall reject such bid. The volume for such types of products may be determined in accordance with such data (which may be market based data) as the Secretary recognizes.

"(B) STUDY OF TYPES OF TESTING STRIP PRODUCTS.—Before 2011, the Inspector Gen-

eral of the Department of Health and Human Services shall conduct a study to determine the types of diabetic testing strip products by volume that could be used to make determinations pursuant to subparagraph (A) for the first competition under the competitive acquisition program described in such subparagraph and submit to the Secretary a report on the results of the study. The Inspector General shall also conduct such a study and submit such a report before the Secretary conducts a subsequent competitive acquistion program described in subparagraph (A).".

(4) OTHER CONFORMING AMENDMENTS.—Section 1847(b)(11) of such Act, as redesignated by paragraph (3), is amended—

(A) in subparagraph (C), by inserting "and the identification of areas under subsection (a)(1)(D)(iii)" after "(a)(1)(A)";

(B) in subparagraph (D), by inserting "and implementation of subsection (a)(1)(D)" after "(a)(1)(B)";

(C) in subparagraph (E), by striking "or" at the end;

(D) in subparagraph (F), by striking the period at the end and inserting "; or"; and

(E) by adding at the end the following new subparagraph:

"(G) the implementation of the special rule described in paragraph (10).".

(5) FUNDING FOR IMPLEMENTATION.—In addition to funds otherwise available, for purposes of implementing the provisions of, and amendments made by, this section, other than the amendment made by subsection (c)(1) and other than section 1847(a)(1)(E) of the Social Security Act, the Secretary of Health and Human Services shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) to the Centers for Medicare & Medicaid Services Program Management Account of $20,000,000 for fiscal year 2008, and $25,000,000 for each of fiscal years 2009 through 2012. Amounts transferred under this paragraph for a fiscal year shall be available until expended.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect as of June 30, 2008.

Subtitle D—Provisions Relating to Part C

SEC. 161. PHASE-OUT OF INDIRECT MEDICAL EDUCATION (IME).

(a) IN GENERAL.—Section 1853(k) of the Social Security Act (42 U.S.C. 1395w–23(k)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking "paragraph (2)" and inserting "paragraphs (2) and (4)"; and

(2) by adding at the end the following new paragraph:

"(4) PHASE-OUT OF THE INDIRECT COSTS OF MEDICAL EDUCATION FROM CAPITATION RATES.—

"(A) IN GENERAL.—After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2010), the Secretary shall adjust such applicable amount to exclude from such applicable amount the phase-in percentage (as defined in subparagraph (B)(i)) for the year of the Secretary's estimate of the standardized costs for payments under section 1886(d)(5)(B) in the area for the year. Any adjustment under the preceding sentence shall be made prior to the application of paragraph (2).

"(B) PERCENTAGES DEFINED.—For purposes of this paragraph:

"(i) PHASE-IN PERCENTAGE.—The term 'phase-in percentage' means, for an area for a year, the ratio (expressed as a percentage, but in no case greater than 100 percent) of—

"(I) the maximum cumulative adjustment percentage for the year (as defined in clause (ii)); to

"(II) the standardized IME cost percentage (as defined in clause (iii)) for the area and year.

"(ii) MAXIMUM CUMULATIVE ADJUSTMENT PERCENTAGE.—The term 'maximum cumulative adjustment percentage' means, for—

"(I) 2010, 0.60 percent; and

"(II) a subsequent year, the maximum cumulative adjustment percentage for the previous year increased by 0.60 percentage points.

"(iii) STANDARDIZED IME COST PERCENTAGE.—The term 'standardized IME cost percentage' means, for an area for a

year, the per capita costs for payments under section 1886(d)(5)(B) (expressed as a percentage of the fee-for-service amount specified in subparagraph (C)) for the area and the year.

"(C) FEE-FOR-SERVICE AMOUNT.—The fee-for-service amount specified in this subparagraph for an area for a year is the amount specified under subsection (c)(1)(D) for the area and the year.".

(b) EXCLUDING ADJUSTMENT FROM THE UPDATE.—Section 1853(k)(1)(B)(i) of the Social Security Act (42 U.S.C. 1395w–23(k)(1)(B)(i)) is amended by striking "paragraph (2)" and inserting "paragraphs (2) and (4)".

(c) HOLD HARMLESS FOR PACE PROGRAM PAYMENTS.—Section 1894(d) of the Social Security Act (42 U.S.C. 1395eee(d)) is amended by adding at the end the following new paragraph:

"(3) CAPITATION RATES DETERMINED WITHOUT REGARD TO THE PHASE-OUT OF THE INDIRECT COSTS OF MEDICAL EDUCATION FROM THE ANNUAL MEDICARE ADVANTAGE CAPITATION RATE.—Capitation amounts under this subsection shall be deter-

mined without regard to the application of section 1853(k)(4).".

SEC. 162. REVISIONS TO REQUIREMENTS FOR MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.

(a) REQUIREMENTS TO ASSURE ACCESS TO NETWORK COVERAGE.—

(1) INDIVIDUAL MARKET.—Section 1852(d) of the Social Security Act (42 U.S.C. 1395w–22(d)) is amended—

(A) in paragraph (4), in the second sentence, by striking "The Secretary" and inserting "Subject to paragraph (5), the Secretary"; and

(B) by adding at the end the following new paragraph:

"(5) REQUIREMENT OF CERTAIN NON-EMPLOYER MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS TO USE CONTRACTS WITH PROVIDERS.—

"(A) IN GENERAL.—For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan not described in paragraph (1) or (2) of section 1857(i) operating in a network area (as defined

in subparagraph (B)), the plan shall meet the access standards under paragraph (4) in that area only through entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment of payment rates meeting the requirements under subparagraph (A) of such paragraph.

"(B) NETWORK AREA DEFINED.—For purposes of subparagraph (A), the term 'network area' means, for a plan year, an area which the Secretary identifies (in the Secretary's announcement of the proposed payment rates for the previous plan year under section 1853(b)(1)(B)) as having at least 2 network-based plans (as defined in subparagraph (C)) with enrollment under this part as of the first day of the year in which such announcement is made.

"(C) NETWORK-BASED PLAN DEFINED.—

"(i) IN GENERAL.—For purposes of subparagraph (B), the term 'network-based plan' means—

"(I) except as provided in clause (ii), a Medicare Advantage plan that

is a coordinated care plan described in section 1851(a)(2)(A)(i);

"(II) a network-based MSA plan; and

"(III) a reasonable cost reimbursement plan under section 1876.

"(ii) EXCLUSION OF NON-NETWORK REGIONAL PPOS.—The term 'network-based plan' shall not include an MA regional plan that, with respect to the area, meets access adequacy standards under this part substantially through the authority of section 422.112(a)(1)(ii) of title 42, Code of Federal Regulations, rather than through written contracts.".

(2) EMPLOYER PLANS.—Section 1852(d) of the Social Security Act (42 U.S.C. 1395w–22(d)), as amended by paragraph (1), is amended—

(A) in paragraph (4), in the second sentence, by striking "paragraph (5)" and inserting "paragraphs (5) and (6)"; and

(B) by adding at the end the following new paragraph:

"(6) REQUIREMENT OF ALL EMPLOYER MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS

TO USE CONTRACTS WITH PROVIDERS.—For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan that is described in paragraph (1) or (2) of section 1857(i), the plan shall meet the access standards under paragraph (4) only through entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment of payment rates meeting the requirements under subparagraph (A) of such paragraph.''.

(3) ACCESS REQUIREMENTS.—

(A) IN GENERAL.—Section 1852(d)(4)(B) of the Social Security Act (42 U.S.C. 1395w–22(d)(4)(B)) is amended by striking ''a sufficient number'' through ''terms of the plan'' and inserting ''a sufficient number and range of providers within such category to meet the access standards in subparagraphs (A) through (E) of paragraph (1)''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to plan year 2010 and subsequent plan years.

(b) CLARIFICATION REGARDING UTILIZATION.—Section 1859(b)(2) of the Social Security Act (42 U.S.C.

1395w–28(b)(2)) is amended by adding at the end the following flush sentence:

"Nothing in subparagraph (B) shall be construed to preclude a plan from varying rates for such a provider based on the specialty of the provider, the location of the provider, or other factors related to such provider that are not related to utilization, or to preclude a plan from increasing rates for such a provider based on increased utilization of specified preventive or screening services.".

SEC. 163. REVISIONS TO QUALITY IMPROVEMENT PROGRAMS.

(a) REQUIREMENT FOR MA PRIVATE FEE-FOR-SERVICE AND MSA PLANS TO HAVE A QUALITY IMPROVEMENT PROGRAM.—Section 1852(e)(1) of the Social Security Act (42 U.S.C. 1395w–22(e)(1)) is amended by striking "(other than an MA private fee-for-service plan or an MSA plan)".

(b) DATA COLLECTION REQUIREMENTS FOR MA REGIONAL PLANS, MA PRIVATE FEE-FOR-SERVICE PLANS, AND MSA PLANS.—Section 1852(e)(3)(A) of the Social Security Act (42 U.S.C. 1395w–22(e)(3)(A)) is amended—

(1) in clause (i), by adding at the end the following new sentence: "With respect to MA private

fee-for-service plans and MSA plans, the requirements under the preceding sentence may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans, except that, for plan year 2010, the limitation under clause (iii) shall not apply and such requirements shall apply only with respect to administrative claims data."

(2) by striking clause (ii); and

(3) in clause (iii)—

(A) in the heading—

(i) by inserting "LOCAL" after "TO"; and

(ii) by inserting "AND MA REGIONAL PLANS" after "ORGANIZATIONS"; and

(B) by inserting "and to MA regional plans" after "organization plans".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning on or after January 1, 2010.

SEC. 164. REVISIONS RELATING TO SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS.

(a) EXTENSION OF AUTHORITY TO RESTRICT ENROLLMENT.—Section 1859(f) of the Social Security Act

(42 U.S.C. 1395w–28(f)), as amended by section 108(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is amended by striking "2010" and inserting "2011".

(b) MORATORIUM ON AUTHORITY TO DESIGNATE OTHER PLANS AS SPECIALIZED MA PLANS.—During the period beginning on January 1, 2010, and ending on December 31, 2010, the Secretary of Health and Human Services may not exercise the authority provided under section 231(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–21 note) to designate other plans as specialized MA plans for special needs individuals..

(c) REQUIREMENTS FOR ENROLLMENT.—

(1) IN GENERAL.—Section 1859 of the Social Security Act (42 U.S.C. 1395w–28) is amended—

(A) in subsection (b)(6)(A), by inserting "and that, as of January 1, 2010, meets the applicable requirements of paragraph (2), (3), or (4) of subsection (f), as the case may be" before the period at the end; and

(B) in subsection (f)—

(i) by amending the heading to read as follows: "REQUIREMENTS REGARDING

ENROLLMENT IN SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS";

(ii) by designating the sentence beginning "In the case of" as paragraph (1) with the heading "REQUIREMENTS FOR ENROLLMENT.—" and with appropriate indentation; and

(iii) by adding at the end the following new paragraphs:

"(2) ADDITIONAL REQUIREMENTS FOR INSTITUTIONAL SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(i), the applicable requirements described in this paragraph are as follows:

"(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individuals described in subsection (b)(6)(B)(i). In the case of an individual who is living in the community but requires an institutional level of care, such individual shall not be considered a special needs individual described in subsection (b)(6)(B)(i) unless the determination that the individual requires an institutional level of care was made—

"(i) using a State assessment tool of the State in which the individual resides; and

"(ii) by an entity other than the organization offering the plan.

"(B) The plan meets the requirements described in paragraph (5).

"(3) ADDITIONAL REQUIREMENTS FOR DUAL SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii), the applicable requirements described in this paragraph are as follows:

"(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individuals described in subsection (b)(6)(B)(ii).

"(B) The plan meets the requirements described in paragraph (5).

"(C) The plan provides each prospective enrollee, prior to enrollment, with a comprehensive written statement (using standardized content and format established by the Secretary) that describes—

"(i) the benefits and cost-sharing protections that the individual is entitled to

under the State Medicaid program under title XIX; and

"(ii) which of such benefits and cost-sharing protections are covered under the plan.

Such statement shall be included with any description of benefits offered by the plan.

"(D) The plan has a contract with the State Medicaid agency to provide benefits, or arrange for benefits to be provided, for which such individual is entitled to receive as medical assistance under title XIX. Such benefits may include long-term care services consistent with State policy.

"(4) ADDITIONAL REQUIREMENTS FOR SEVERE OR DISABLING CHRONIC CONDITION SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii), the applicable requirements described in this paragraph are as follows:

"(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individual described in subsection (b)(6)(B)(iii).

"(B) The plan meets the requirements described in paragraph (5).".

(2) AUTHORITY TO OPERATE BUT NO SERVICE AREA EXPANSION FOR DUAL SNPS THAT DO NOT MEET CERTAIN REQUIREMENTS.—Notwithstanding subsection (f) of section 1859 of the Social Security Act (42 U.S.C. 1395w–28), during the period beginning on January 1, 2010, and ending on December 31, 2010, in the case of a specialized Medicare Advantage plan for special needs individuals described in subsection (b)(6)(B)(ii) of such section, as amended by this section, that does not meet the requirement described in subsection (f)(3)(D) of such section, the Secretary of Health and Human Services—

(A) shall permit such plan to be offered under part C of title XVIII of such Act; and

(B) shall not permit an expansion of the service area of the plan under such part C.

(3) RESOURCES FOR STATE MEDICAID AGENCIES.—The Secretary of Health and Human Services shall provide for the designation of appropriate staff and resources that can address State inquiries with respect to the coordination of State and Federal policies for specialized MA plans for special

needs individuals described in section 1859(b)(6)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(ii)), as amended by this section.

(4) NO REQUIREMENT FOR CONTRACT.—Nothing in the provisions of, or amendments made by, this subsection shall require a State to enter into a contract with a Medicare Advantage organization with respect to a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(ii)), as amended by this section.

(d) CARE MANAGEMENT REQUIREMENTS FOR ALL SNPS.—

(1) REQUIREMENTS.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)), as amended by subsection (c)(1), is amended by adding at the end the following new paragraph:

"(5) CARE MANAGEMENT REQUIREMENTS FOR ALL SNPS.—The requirements described in this paragraph are that the organization offering a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(i)—

"(A) have in place an evidenced-based model of care with appropriate networks of providers and specialists; and

"(B) with respect to each individual enrolled in the plan—

"(i) conduct an initial assessment and an annual reassessment of the individual's physical, psychosocial, and functional needs;

"(ii) develop a plan, in consultation with the individual as feasible, that identifies goals and objectives, including measurable outcomes as well as specific services and benefits to be provided; and

"(iii) use an interdisciplinary team in the management of care.".

(2) REVIEW TO ENSURE COMPLIANCE WITH CARE MANAGEMENT REQUIREMENTS.—Section 1857(d) of the Social Security Act (42 U.S.C. 1395w–27(d)) is amended by adding at the end the following new paragraph:

"(6) REVIEW TO ENSURE COMPLIANCE WITH CARE MANAGEMENT REQUIREMENTS FOR SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS.—In conjunction with the peri-

odic audit of a specialized Medicare Advantage plan for special needs individuals under paragraph (1), the Secretary shall conduct a review to ensure that such organization offering the plan meets the requirements described in section 1859(f)(5).".

(e) CLARIFICATION OF THE DEFINITION OF A SEVERE OR DISABLING CHRONIC CONDITIONS SPECIALIZED NEEDS INDIVIDUAL.—

(1) IN GENERAL.—Section 1859(b)(6)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(iii)) is amended by inserting "who have one or more comorbid and medically complex chronic conditions that are substantially disabling or life threatening, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems across domains of care" before the period at the end.

(2) PANEL.—The Secretary of Health and Human Services shall convene a panel of clinical advisors to determine the conditions that meet the definition of severe and disabling chronic conditions under section 1859(b)(6)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(iii)), as amended by paragraph (1). The panel shall include

the Director of the Agency for Healthcare Research and Quality (or the Director's designee).

(f) SPECIAL REQUIREMENTS REGARDING QUALITY REPORTING FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

(1) IN GENERAL.—Section 1852(e)(3)(A) of the Social Security Act (42 U.S.C. 1395w–22(e)(3)(A)), as amended by section 163, is amended by inserting after clause (i) the following new clause:

"(ii) SPECIAL REQUIREMENTS FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—In addition to the data required to be collected, analyzed, and reported under clause (i) and notwithstanding the limitations under subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization offering a specialized Medicare Advantage plan for special needs individuals shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality with respect to the requirements described in paragraphs (2) through (5) of subsection (f). Such

data may be based on claims data and shall be at the plan level.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on a date specified by the Secretary of Health and Human Services (but in no case later than January 1, 2010), and shall apply to all specialized Medicare Advantage plans for special needs individuals regardless of when the plan first entered the Medicare Advantage program under part C of title XVIII of the Social Security Act.

(g) EFFECTIVE DATE AND APPLICATION.—The amendments made by subsections (c)(1), (d), and (e)(1) shall apply to plan years beginning on or after January 1, 2010, and shall apply to all specialized Medicare Advantage plans for special needs individuals regardless of when the plan first entered the Medicare Advantage program under part C of title XVIII of the Social Security Act.

(h) NO AFFECT ON MEDICAID BENEFITS FOR DUALS.—Nothing in the provisions of, or amendments made by, this section shall affect the benefits available under the Medicaid program under title XIX of the Social Security Act for special needs individuals described in section 1859(b)(6)(B)(ii) of such Act (42 U.S.C. 1395w–28(b)(6)(B)(ii)).

SEC. 165. LIMITATION ON OUT-OF-POCKET COSTS FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES ENROLLED IN A SPECIALIZED MEDICARE ADVANTAGE PLAN FOR SPECIAL NEEDS INDIVIDUALS.

(a) IN GENERAL.—Section 1852(a) of the Social Security Act (42 U.S.C. 1395w–22(a)) is amended by adding at the end the following new paragraph:

"(7) LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—In the case of an individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a qualified Medicare beneficiary (as defined in section 1905(p)(1)) and who is enrolled in a specialized Medicare Advantage plan for special needs individuals described in section 1859(b)(6)(B)(ii), the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such plan.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to plan years beginning on or after January 1, 2010.

SEC. 166. ADJUSTMENT TO THE MEDICARE ADVANTAGE STABILIZATION FUND.

Section 1858(e)(2)(A)(i) of the Social Security Act (42 U.S.C. 1395w–27a(e)(2)(A)(i)), as amended by section 110 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended—

(1) by striking "2013" and inserting "2014"; and

(2) by striking "$1,790,000,000" and inserting "$1".

SEC. 167. ACCESS TO MEDICARE REASONABLE COST CONTRACT PLANS.

(a) EXTENSION OF REASONABLE COST CONTRACTS.—Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)), as amended by section 109 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking "January 1, 2009" and inserting "January 1, 2010" in the matter preceding subclause (I).

(b) REQUIREMENT FOR AT LEAST TWO MEDICARE ADVANTAGE ORGANIZATIONS TO BE OFFERING A PLAN IN AN AREA FOR THE PROHIBITION TO BE APPLICABLE.—Subclauses (I) and (II) of section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) are each amended by inserting ",

provided that all such plans are not offered by the same Medicare Advantage organization'' after ''clause (iii)''.

(c) REVISION OF REQUIREMENTS FOR A PLAN THAT ARE USED TO DETERMINE IF PROHIBITION IS APPLICABLE.—

(1) IN GENERAL.—Section 1876(h)(5)(C)(iii)(I) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(iii)(I)) is amended by inserting ''that are not in another Metropolitan Statistical Area with a population of more than 250,000'' after ''such Metropolitan Statistical Area''.

(2) CLARIFICATION.—Section 1876(h)(5)(C)(iii)(I) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(iii)(I)) is amended by adding at the end the following new sentence: ''If the service area includes a portion in more than 1 Metropolitan Statistical Area with a population of more than 250,000, the minimum enrollment determination under the preceding sentence shall be made with respect to each such Metropolitan Statistical Area (and such applicable contiguous counties to such Metropolitan Statistical Area).''.

(d) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of the reasons

(if any) why reasonable cost contracts under section 1876(h) of the Social Security Act (42 U.S.C. 1395mm(h)) are unable to become Medicare Advantage plans under part C of title XVIII of such Act.

(2) REPORT.—Not later than December 31, 2009, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SEC. 168. MEDPAC STUDY AND REPORT ON QUALITY MEASURES.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on how comparable measures of performance and patient experience can be collected and reported by 2011 for the Medicare Advantage program under part C of title XVIII of the Social Security Act and the original Medicare fee-for-service program under parts A and B of such title. Such study shall address technical issues, such as data requirements, in addition to issues relating to appropriate quality benchmarks that—

(1) compare the quality of care Medicare beneficiaries receive across Medicare Advantage plans; and

(2) compare the quality of care Medicare beneficiaries receive under Medicare Advantage plans and under the original Medicare fee-for-service program.

(b) REPORT.—Not later than March 31, 2010, the Medicare Payment Advisory Commission shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Medicare Payment Advisory Commission determines appropriate.

SEC. 169. MEDPAC STUDY AND REPORT ON MEDICARE ADVANTAGE PAYMENTS.

(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the "Commission") shall conduct a study of the following:

(1) The correlation between—

(A) the costs that Medicare Advantage organizations with respect to Medicare Advantage plans incur in providing coverage under the plan for items and services covered under the original Medicare fee-for-service program under

parts A and B of title XVIII of the Social Security Act, as reflected in plan bids; and

(B) county-level spending under such original Medicare fee-for-service program on a per capita basis, as calculated by the Chief Actuary of the Centers for Medicare & Medicaid Services.

The study with respect to the issue described in the preceding sentence shall include differences in correlation statistics by plan type and geographic area.

(2) Based on these results of the study with respect to the issue described in paragraph (1), and other data the Commission determines appropriate—

(A) alternate approaches to payment with respect to a Medicare beneficiary enrolled in a Medicare Advantage plan other than through county-level payment area equivalents.

(B) the accuracy and completeness of county-level estimates of per capita spending under such original Medicare fee-for-service program (including counties in Puerto Rico), as used to determine the annual Medicare Advantage capitation rate under section 1853 of the

Social Security Act (42 U.S.C. 1395w–23), and whether such estimates include—

(i) expenditures with respect to Medicare beneficiaries at facilities of the Department of Veterans Affairs; and

(ii) all appropriate administrative expenses, including claims processing.

(3) Ways to improve the accuracy and completeness of county-level estimates of per capita spending described in paragraph (2)(B).

(b) REPORT.—Not later than March 31, 2010, the Commission shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

Subtitle E—Provisions Relating to Part D

PART I—IMPROVING PHARMACY ACCESS

SEC. 171. PROMPT PAYMENT BY PRESCRIPTION DRUG PLANS AND MA–PD PLANS UNDER PART D.

(a) PROMPT PAYMENT BY PRESCRIPTION DRUG PLANS.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)) is amended by adding at the end the following new paragraph:

"(4) PROMPT PAYMENT OF CLEAN CLAIMS.—

"(A) PROMPT PAYMENT.—

"(i) IN GENERAL.—Each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to all clean claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only or are located in, or contract with, a long-term care facility) under this part within the applicable number of calendar days after the date on which the claim is received.

"(ii) CLEAN CLAIM DEFINED.—In this paragraph, the term 'clean claim' means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part.

"(iii) DATE OF RECEIPT OF CLAIM.—In this paragraph, a claim is considered to have been received—

"(I) with respect to claims submitted electronically, on the date on which the claim is transferred; and

"(II) with respect to claims submitted otherwise, on the 5th day after the postmark date of the claim or the date specified in the time stamp of the transmission.

"(B) APPLICABLE NUMBER OF CALENDAR DAYS DEFINED.—In this paragraph, the term 'applicable number of calendar days' means—

"(i) with respect to claims submitted electronically, 14 days; and

"(ii) with respect to claims submitted otherwise, 30 days.

"(C) INTEREST PAYMENT.—

"(i) IN GENERAL.—Subject to clause (ii), if payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in subparagraph (B)) after a clean claim is received, the PDP sponsor shall pay inter-

est to the pharmacy that submitted the claim at a rate equal to the weighted average of interest on 3-month marketable Treasury securities determined for such period, increased by 0.1 percentage point for the period beginning on the day after the required payment date and ending on the date on which payment is made (as determined under subparagraph (D)(iv)). Interest amounts paid under this subparagraph shall not be counted against the administrative costs of a prescription drug plan or treated as allowable risk corridor costs under section 1860D–15(e).

"(ii) AUTHORITY NOT TO CHARGE INTEREST.—The Secretary may provide that a PDP sponsor is not charged interest under clause (i) in the case where there are exigent circumstances, including natural disasters and other unique and unexpected events, that prevent the timely processing of claims.

"(D) PROCEDURES INVOLVING CLAIMS.—

"(i) CLAIM DEEMED TO BE CLEAN.—A claim is deemed to be a clean claim if

the PDP sponsor involved does not provide notice to the claimant of any deficiency in the claim—

"(I) with respect to claims submitted electronically, within 10 days after the date on which the claim is received; and

"(II) with respect to claims submitted otherwise, within 15 days after the date on which the claim is received.

"(ii) CLAIM DETERMINED TO NOT BE A CLEAN CLAIM.—

"(I) IN GENERAL.—If a PDP sponsor determines that a submitted claim is not a clean claim, the PDP sponsor shall, not later than the end of the period described in clause (i), notify the claimant of such determination. Such notification shall specify all defects or improprieties in the claim and shall list all additional information or documents necessary for the proper processing and payment of the claim.

"(II) DETERMINATION AFTER SUBMISSION OF ADDITIONAL INFORMATION.—A claim is deemed to be a clean claim under this paragraph if the PDP sponsor involved does not provide notice to the claimant of any defect or impropriety in the claim within 10 days of the date on which additional information is received under subclause (I).

"(iii) OBLIGATION TO PAY.—A claim submitted to a PDP sponsor that is not paid or contested by the sponsor within the applicable number of days (as defined in subparagraph (B)) after the date on which the claim is received shall be deemed to be a clean claim and shall be paid by the PDP sponsor in accordance with subparagraph (A).

"(iv) DATE OF PAYMENT OF CLAIM.—Payment of a clean claim under such subparagraph is considered to have been made on the date on which—

"(I) with respect to claims paid electronically, the payment is transferred; and

"(II) with respect to claims paid otherwise, the payment is submitted to the United States Postal Service or common carrier for delivery.

"(E) ELECTRONIC TRANSFER OF FUNDS.—A PDP sponsor shall pay all clean claims submitted electronically by electronic transfer of funds if the pharmacy so requests or has so requested previously. In the case where such payment is made electronically, remittance may be made by the PDP sponsor electronically as well.

"(F) PROTECTING THE RIGHTS OF CLAIMANTS.—

"(i) IN GENERAL.—Nothing in this paragraph shall be construed to prohibit or limit a claim or action not covered by the subject matter of this section that any individual or organization has against a provider or a PDP sponsor.

"(ii) ANTI-RETALIATION.—Consistent with applicable Federal or State law, a

PDP sponsor shall not retaliate against an individual or provider for exercising a right of action under this subparagraph.

"(G) RULE OF CONSTRUCTION.—A determination under this paragraph that a claim submitted by a pharmacy is a clean claim shall not be construed as a positive determination regarding eligibility for payment under this title, nor is it an indication of government approval of, or acquiescence regarding, the claim submitted. The determination shall not relieve any party of civil or criminal liability with respect to the claim, nor does it offer a defense to any administrative, civil, or criminal action with respect to the claim.".

(b) PROMPT PAYMENT BY MA–PD PLANS.—Section 1857(f) of the Social Security Act (42 U.S.C. 1395w–27) is amended by adding at the end the following new paragraph:

"(3) INCORPORATION OF CERTAIN PRESCRIPTION DRUG PLAN CONTRACT REQUIREMENTS.—The following provisions shall apply to contracts with a Medicare Advantage organization offering an MA–PD plan in the same manner as they apply to con-

tracts with a PDP sponsor offering a prescription drug plan under part D:

"(A) PROMPT PAYMENT.—Section 1860D–12(b)(4).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning on or after January 1, 2010.

SEC. 172. REGULAR UPDATE OF PRESCRIPTION DRUG PRICING STANDARD.

(a) REQUIREMENT FOR PRESCRIPTION DRUG PLANS.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)), as amended by section 171(a)(1), is amended by adding at the end the following new paragraph:

"(5) REGULAR UPDATE OF PRESCRIPTION DRUG PRICING STANDARD.—If the PDP sponsor of a prescription drug plan uses a standard for reimbursement of pharmacies based on the cost of a drug, each contract entered into with such sponsor under this part with respect to the plan shall provide that the sponsor shall update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the drug.".

(b) REQUIREMENT FOR MA–PD PLANS.—Section 1857(f)(3) of the Social Security Act, as amended by section 171(a)(2), is amended by adding at the end the following new subparagraph:

"(B) REGULAR UPDATE OF PRESCRIPTION DRUG PRICING STANDARD.—Section 1860D–12(b)(6).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning on or after January 1, 2009.

PART II—OTHER PROVISIONS

SEC. 175. INCLUSION OF BARBITURATES AND BENZODIAZEPINES AS COVERED PART D DRUGS.

(a) IN GENERAL.—Section 1860D–2(e)(2)(A) of the Social Security Act (42 U.S.C. 1395w–102(e)(2)(A)) is amended by inserting after "agents)," the following "other than subparagraph (I) of such section (relating to barbiturates) if the barbiturate is used in the treatment of epilepsy, cancer, or a chronic mental health disorder, and other than subparagraph (J) of such section (relating to benzodiazepines),".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to prescriptions dispensed on or after January 1, 2013.

SEC. 176. FORMULARY REQUIREMENTS WITH RESPECT TO CERTAIN CATEGORIES OR CLASSES OF DRUGS.

Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)) is amended—

(1) in subparagraph (C)(i), by striking "The formulary" and inserting "Subject to subparagraph (G), the formulary"; and

(2) by inserting after subparagraph (F) the following new subparagraph:

"(G) REQUIRED INCLUSION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

"(i) IDENTIFICATION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—Beginning with plan year 2010, the Secretary shall identify, as appropriate, categories and classes of drugs for which both of the following criteria are met:

"(I) Restricted access to drugs in the category or class would have major or life threatening clinical consequences for individuals who have a disease or disorder treated by the drugs in such category or class.

"(II) There is significant clinical need for such individuals to have ac-

cess to multiple drugs within a category or class due to unique chemical actions and pharmacological effects of the drugs within the category or class, such as drugs used in the treatment of cancer.

"(ii) FORMULARY REQUIREMENTS.—Subject to clause (iii), PDP sponsors offering prescription drug plans shall be required to include all covered part D drugs in the categories and classes identified by the Secretary under clause (i).

"(iii) EXCEPTIONS.—The Secretary may establish exceptions that permits a PDP sponsor of a prescription drug plan to exclude from its formulary a particular covered part D drug in a category or class that is otherwise required to be included in the formulary under clause (ii) (or to otherwise limit access to such a drug, including through prior authorization or utilization management). Any exceptions established under the preceding sentence shall be provided under a process that—

"(I) ensures that any exception to such requirement is based upon scientific evidence and medical standards of practice (and, in the case of antiretroviral medications, is consistent with the Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents); and

"(II) includes a public notice and comment period.".

Subtitle F—Other Provisions

SEC. 181. USE OF PART D DATA.

Section 1860D–12(b)(3)(D) of the Social Security Act (42 U.S.C. 1395w–112(b)(3)(D)) is amended by adding at the end the following sentence: "Notwithstanding any other provision of law, information provided to the Secretary under the application of section 1857(e)(1) to contracts under this section under the preceding sentence—

"(i) may be used for the purposes of carrying out this part, improving public health through research on the utilization, safety, effectiveness, quality, and efficiency

of health care services (as the Secretary determines appropriate); and

"(ii) shall be made available to Congressional support agencies (in accordance with their obligations to support Congress as set out in their authorizing statutes) for the purposes of conducting Congressional oversight, monitoring, making recommendations, and analysis of the program under this title.".

SEC. 182. REVISION OF DEFINITION OF MEDICALLY ACCEPTED INDICATION FOR DRUGS.

(a) REVISION OF DEFINITION FOR PART D DRUGS.—

(1) IN GENERAL.—Section 1860D–2(e)(1) of the Social Security Act (42 U.S.C. 1395w–102(e)(1)) is amended, in the matter following subparagraph (B)—

(A) by striking "(as defined in section 1927(k)(6))" and inserting "(as defined in paragraph (4))"; and

(B) by adding at the end the following new paragraph:

"(4) MEDICALLY ACCEPTED INDICATION DEFINED.—

"(A) IN GENERAL.—For purposes of paragraph (1), the term 'medically accepted indication' has the meaning given that term—

"(i) in the case of a covered part D drug used in an anticancer chemotherapeutic regimen, in section 1861(t)(2)(B), except that in applying such section—

"(I) 'prescription drug plan or MA–PD plan' shall be substituted for 'carrier' each place it appears; and

"(II) subject to subparagraph (B), the compendia described in section 1927(g)(1)(B)(i)(III) shall be included in the list of compendia described in clause (ii)(I) section 1861(t)(2)(B); and

"(ii) in the case of any other covered part D drug, in section 1927(k)(6).

"(B) CONFLICT OF INTEREST.—On and after January 1, 2010, subparagraph (A)(i)(II) shall not apply unless the compendia described in section 1927(g)(1)(B)(i)(III) meets the requirement in the third sentence of section 1861(t)(2)(B).

"(C) UPDATE.—For purposes of applying subparagraph (A)(ii), the Secretary shall revise the list of compendia described in section 1927(g)(1)(B)(i) as is appropriate for identifying medically accepted indications for drugs. Any such revision shall be done in a manner consistent with the process for revising compendia under section 1861(t)(2)(B).".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2009.

(b) CONFLICTS OF INTEREST.—Section 1861(t)(2)(B) of the Social Security Act (42 U.S.C. 1395x(t)(2)(B)) is amended by adding at the end the following new sentence: "On and after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.".

SEC. 183. CONTRACT WITH A CONSENSUS-BASED ENTITY REGARDING PERFORMANCE MEASUREMENT.

(a) CONTRACT.—

(1) IN GENERAL.—Part E of title XVIII of the Social Security Act (42 U.S.C. 1395x et seq.) is

amended by inserting after section 1889 the following new section:

"CONTRACT WITH A CONSENSUS-BASED ENTITY REGARDING PERFORMANCE MEASUREMENT

"SEC. 1890. (a) CONTRACT.—

"(1) IN GENERAL.—For purposes of activities conducted under this Act, the Secretary shall identify and have in effect a contract with a consensus-based entity, such as the National Quality Forum, that meets the requirements described in subsection (c). Such contract shall provide that the entity will perform the duties described in subsection (b).

"(2) TIMING FOR FIRST CONTRACT.—As soon as practicable after the date of the enactment of this subsection, the Secretary shall enter into the first contract under paragraph (1).

"(3) PERIOD OF CONTRACT.—A contract under paragraph (1) shall be for a period of 4 years (except as may be renewed after a subsequent bidding process).

"(4) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into a contract under paragraph (1).

"(b) DUTIES.—The duties described in this subsection are the following:

"(1) PRIORITY SETTING PROCESS.—The entity shall synthesize evidence and convene key stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings. In making such recommendations, the entity shall—

"(A) ensure that priority is given to measures—

"(i) that address the health care provided to patients with prevalent, high-cost chronic diseases;

"(ii) with the greatest potential for improving the quality, efficiency, and patient-centeredness of health care; and

"(iii) that may be implemented rapidly due to existing evidence, standards of care, or other reasons; and

"(B) take into account measures that—

"(i) may assist consumers and patients in making informed health care decisions;

"(ii) address health disparities across groups and areas; and

"(iii) address the continuum of care a patient receives, including services furnished by multiple health care providers or practitioners and across multiple settings.

"(2) ENDORSEMENT OF MEASURES.—The entity shall provide for the endorsement of standardized health care performance measures. The endorsement process under the preceding sentence shall consider whether a measure—

"(A) is evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics, such as health status, language capabilities, race or ethnicity, and income level; and

"(B) is consistent across types of health care providers, including hospitals and physicians.

"(3) MAINTENANCE OF MEASURES.—The entity shall establish and implement a process to ensure that measures endorsed under paragraph (2) are up-

dated (or retired if obsolete) as new evidence is developed.

"(4) PROMOTION OF THE DEVELOPMENT OF ELECTRONIC HEALTH RECORDS.—The entity shall promote the development and use of electronic health records that contain the functionality for automated collection, aggregation, and transmission of performance measurement information.

"(5) ANNUAL REPORT TO CONGRESS AND THE SECRETARY; SECRETARIAL PUBLICATION AND COMMENT.—

"(A) ANNUAL REPORT.—By not later than March 1 of each year (beginning with 2009), the entity shall submit to Congress and the Secretary a report containing a description of—

"(i) the implementation of quality measurement initiatives under this Act and the coordination of such initiatives with quality initiatives implemented by other payers;

"(ii) the recommendations made under paragraph (1); and

"(iii) the performance by the entity of the duties required under the contract en-

tered into with the Secretary under subsection (a).

"(B) SECRETARIAL REVIEW AND PUBLICATION OF ANNUAL REPORT.—Not later than 6 months after receiving a report under subparagraph (A) for a year, the Secretary shall—

"(i) review such report; and

"(ii) publish such report in the Federal Register, together with any comments of the Secretary on such report.

"(c) REQUIREMENTS DESCRIBED.—The requirements described in this subsection are the following:

"(1) PRIVATE NONPROFIT.—The entity is a private nonprofit entity governed by a board.

"(2) BOARD MEMBERSHIP.—The members of the board of the entity include—

"(A) representatives of health plans and health care providers and practitioners or representatives of groups representing such health plans and health care providers and practitioners;

"(B) health care consumers or representatives of groups representing health care consumers; and

"(C) representatives of purchasers and employers or representatives of groups representing purchasers or employers.

"(3) ENTITY MEMBERSHIP.—The membership of the entity includes persons who have experience with—

"(A) urban health care issues;

"(B) safety net health care issues;

"(C) rural and frontier health care issues; and

"(D) health care quality and safety issues.

"(4) OPEN AND TRANSPARENT.—With respect to matters related to the contract with the Secretary under subsection (a), the entity conducts its business in an open and transparent manner and provides the opportunity for public comment on its activities.

"(5) VOLUNTARY CONSENSUS STANDARDS SETTING ORGANIZATION.—The entity operates as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Public Law 104–113) and Office of Management and Budget Revised Circular A–119 (published in the Federal Register on February 10, 1998).

"(6) EXPERIENCE.—The entity has at least 4 years of experience in establishing national consensus standards.

"(7) MEMBERSHIP FEES.—If the entity requires a membership fee for participation in the functions of the entity, such fees shall be reasonable and adjusted based on the capacity of the potential member to pay the fee. In no case shall membership fees pose a barrier to the participation of individuals or groups with low or nominal resources to participate in the functions of the entity.

"(d) FUNDING.—For purposes of carrying out this section, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $10,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2009 through 2012.".

(2) SENSE OF THE SENATE.—It is the Sense of the Senate that the selection by the Secretary of Health and Human Services of an entity to contract with under section 1890(a) of the Social Security Act, as added by paragraph (1), should not be con-

strued as diminishing the significant contributions of the Boards of Medicine, the quality alliances, and other clinical and technical experts to efforts to measure and improve the quality of health care services.

(b) GAO STUDY AND REPORTS ON THE PERFORMANCE AND COSTS OF THE CONSENSUS-BASED ENTITY UNDER THE CONTRACT.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on—

(A) the performance of the entity with a contract with the Secretary of Health and Human Services under section 1890(a) of the Social Security Act, as added by subsection (a), of its duties under such contract; and

(B) the costs incurred by such entity in performing such duties.

(2) REPORTS.—Not later than 18 months and 36 months after the effective date of the first contract entered into under such section 1890(a), the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and ad-

ministrative action as the Comptroller General determines appropriate.

SEC. 184. COST-SHARING FOR CLINICAL TRIALS.

Section 1833 of the Social Security Act (42 U.S.C. 1395l), as amended by section 151(a), is amended by adding at the end the following new subsection:

"(w) METHODS OF PAYMENT.—The Secretary may develop alternative methods of payment for items and services provided under clinical trials and comparative effectiveness studies sponsored or supported by an agency of the Department of Health and Human Services, as determined by the Secretary, to those that would otherwise apply under this section, to the extent such alternative methods are necessary to preserve the scientific validity of such trials or studies, such as in the case where masking the identity of interventions from patients and investigators is necessary to comply with the particular trial or study design.".

SEC. 185. ADDRESSING HEALTH CARE DISPARITIES.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1808 the following new section:

"ADDRESSING HEALTH CARE DISPARITIES

"SEC. 1809. (a) EVALUATING DATA COLLECTION APPROACHES.—The Secretary shall evaluate approaches for the collection of data under this title, to be performed

in conjunction with existing quality reporting requirements and programs under this title, that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, and gender. In conducting such evaluation, the Secretary shall consider the following objectives:

"(1) Protecting patient privacy.

"(2) Minimizing the administrative burdens of data collection and reporting on providers and health plans participating under this title.

"(3) Improving Medicare program data on race, ethnicity, and gender.

"(b) REPORTS TO CONGRESS.—

"(1) REPORT ON EVALUATION.—Not later than 18 months after the date of the enactment of this section, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

"(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, and gender for the original Medicare fee-for-service program

under parts A and B, the Medicare Advantage program under part C, and the Medicare prescription drug program under part D; and

"(B) include recommendations on the most effective strategies and approaches to reporting HEDIS quality measures as required under section 1852(e)(3) and other nationally recognized quality performance measures, as appropriate, on the basis of race, ethnicity, and gender.

"(2) REPORTS ON DATA ANALYSES.—Not later than 4 years after the date of the enactment of this section, and 4 years thereafter, the Secretary shall submit to Congress a report that includes recommendations for improving the identification of health care disparities for Medicare beneficiaries based on analyses of the data collected under subsection (c).

"(c) IMPLEMENTING EFFECTIVE APPROACHES.—Not later than 24 months after the date of the enactment of this section, the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, and gender.".

SEC. 186. DEMONSTRATION TO IMPROVE CARE TO PREVIOUSLY UNINSURED.

(a) ESTABLISHMENT.—Within one year after the date of the enactment of this Act, the Secretary (in this section referred to as the "Secretary") shall establish a demonstration project to determine the greatest needs and most effective methods of outreach to Medicare beneficiaries who were previously uninsured.

(b) SCOPE.—The demonstration shall be in no fewer than 10 sites, and shall include state health insurance assistance programs, community health centers, community-based organizations, community health workers, and other service providers under parts A, B, and C of title XVIII of the Social Security Act. Grantees that are plans operating under part C shall document that enrollees who were previously uninsured receive the "Welcome to Medicare" physical exam.

(c) DURATION.—The Secretary shall conduct the demonstration project for a period of 2 years.

(d) REPORT AND EVALUATION.—The Secretary shall conduct an evaluation of the demonstration and not later than 1 year after the completion of the project shall submit to Congress a report including the following:

(1) An analysis of the effectiveness of outreach activities targeting beneficiaries who were previously uninsured, such as revising outreach and enrollment

materials (including the potential for use of video information), providing one-on-one counseling, working with community health workers, and amending the Medicare and You handbook.

(2) The effect of such outreach on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.

SEC. 187. OFFICE OF THE INSPECTOR GENERAL REPORT ON COMPLIANCE WITH AND ENFORCEMENT OF NATIONAL STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN MEDICARE.

(a) REPORT.—Not later than two years after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall prepare and publish a report on—

(1) the extent to which Medicare providers and plans are complying with the Office for Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons and the Office of Minority Health's Culturally and Linguistically Appropriate Services Standards in health care; and

(2) a description of the costs associated with or savings related to the provision of language services.

Such report shall include recommendations on improving compliance with CLAS Standards and recommendations on improving enforcement of CLAS Standards.

(b) IMPLEMENTATION.—Not later than one year after the date of publication of the report under subsection (a), the Department of Health and Human Services shall implement changes responsive to any deficiencies identified in the report.

SEC. 188. MEDICARE IMPROVEMENT FUNDING.

(a) MEDICARE IMPROVEMENT FUND.—

(1) IN GENERAL.—Subject to paragraph (2), title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

"MEDICARE IMPROVEMENT FUND

"SEC. 1898. (a) ESTABLISHMENT.—

"The Secretary shall establish under this title a Medicare Improvement Fund (in this section referred to as the 'Fund') which shall be available to the Secretary to make improvements under the original fee-for-service program under parts A and B for individuals entitled to, or enrolled for, benefits under part A or enrolled under part B.

"(b) FUNDING.—

"(1) IN GENERAL.—There shall be available to the Fund, for expenditures from the Fund for services furnished during fiscal years 2014 through 2017, $19,900,000,000.

"(2) PAYMENT FROM TRUST FUNDS.—The amount specified under paragraph (1) shall be available to the Fund, as expenditures are made from the Fund, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines appropriate.

"(3) FUNDING LIMITATION.—Amounts in the Fund shall be available in advance of appropriations but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under paragraph (1). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient amounts to cover all such obligations incurred consistent with the previous sentence.".

(2) CONTINGENCY.—

(A) IN GENERAL.—If there is enacted, before, on, or after the date of the enactment of

this Act, a Supplemental Appropriations Act, 2008 that includes a provision providing for a Medicare Improvement Fund under a section 1898 of the Social Security Act, the alternative amendment described in subparagraph (B)—

(i) shall apply instead of the amendment made by paragraph (1); and

(ii) shall be executed after such provision in such Supplemental Appropriations Act.

(B) ALTERNATIVE AMENDMENT DESCRIBED.—The alternative amendment described in this subparagraph is as follows: Section 1898(b)(1) of the Social Security Act, as added by the Supplemental Appropriations Act, 2008, is amended by inserting before the period at the end the following: " and, in addition for services furnished during fiscal years 2014 through 2017, $19,900,000,000".

(b) IMPLEMENTATION.—For purposes of carrying out the provisions of, and amendments made by, this title, in addition to any other amounts provided in such provisions and amendments, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the

Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–23(f)), of $140,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2009 through 2013.

SEC. 189. INCLUSION OF MEDICARE PROVIDERS AND SUPPLIERS IN FEDERAL PAYMENT LEVY AND ADMINISTRATIVE OFFSET PROGRAM.

(a) IN GENERAL.—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

"(d) INCLUSION OF MEDICARE PROVIDER AND SUPPLIER PAYMENTS IN FEDERAL PAYMENT LEVY PROGRAM.—

"(1) IN GENERAL.—The Centers for Medicare & Medicaid Services shall take all necessary steps to participate in the Federal Payment Levy Program under section 6331(h) of the Internal Revenue Code of 1986 as soon as possible and shall ensure that—

"(A) at least 50 percent of all payments under parts A and B are processed through

such program beginning within 1 year after the date of the enactment of this section;

"(B) at least 75 percent of all payments under parts A and B are processed through such program beginning within 2 years after such date; and

"(C) all payments under parts A and B are processed through such program beginning not later than September 30, 2011.

"(2) ASSISTANCE.—The Financial Management Service and the Internal Revenue Service shall provide assistance to the Centers for Medicare & Medicaid Services to ensure that all payments described in paragraph (1) are included in the Federal Payment Levy Program by the deadlines specified in that subsection.".

(b) APPLICATION OF ADMINISTRATIVE OFFSET PROVISIONS TO MEDICARE PROVIDER OR SUPPLIER PAYMENTS.—Section 3716 of title 31, United States Code, is amended—

(1) by inserting "the Department of Health and Human Services," after "United States Postal Service," in subsection (c)(1)(A); and

(2) by adding at the end of subsection (c)(3) the following new subparagraph:

"(D) This section shall apply to payments made after the date which is 90 days after the enactment of this subparagraph (or such earlier date as designated by the Secretary of Health and Human Services) with respect to claims or debts, and to amounts payable, under title XVIII of the Social Security Act.".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

TITLE J—MEDICAID

SEC. 201. EXTENSION OF TRANSITIONAL MEDICAL ASSISTANCE (TMA) AND ABSTINENCE EDUCATION PROGRAM.

Section 401 of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432, 120 Stat. 2994), as amended by section 1 of Public Law 110–48 (121 Stat. 244), section 2 of the TMA, Abstinence, Education, and QI Programs Extension Act of 2007 (Public Law 110–90, 121 Stat. 984), and section 202 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is amended—

(1) by striking "June 30, 2008" and inserting "June 30, 2009";

(2) by striking "the third quarter of fiscal year 2008" and inserting "the third quarter of fiscal year 2009"; and

(3) by striking "the third quarter of fiscal year 2007" and inserting "the third quarter of fiscal year 2008".

SEC. 202. MEDICAID DSH EXTENSION.

Section 1923(f)(6) of the Social Security Act (42 U.S.C. 1396r–4(f)(6)) is amended—

(1) in the heading, by striking "FISCAL YEAR 2007 AND PORTIONS OF FISCAL YEAR 2008" and inserting "FISCAL YEARS 2007 THROUGH 2009 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2010"; and

(2) in subparagraph (A)—

(A) in clause (i)—

(i) in the second sentence—

(I) by striking "fiscal year 2008 for the period ending on June 30, 2008" and inserting "fiscal years 2008 and 2009"; and

(II) by striking "¾ of"; and

(ii) by adding at the end the following new sentences: "Only with respect to fiscal year 2010 for the period ending on Decem-

ber 31, 2009, the DSH allotment for Tennessee for such portion of the fiscal year, notwithstanding such table or terms, shall be ¼ of the amount specified in the first sentence for fiscal year 2007.";

(B) in clause (ii), by striking "or for a period in fiscal year 2008" and inserting ", 2008, 2009, or for a period in fiscal year 2010";

(C) in clause (iv)—

(i) in the heading, by striking "FISCAL YEAR 2007 AND FISCAL YEAR 2008" and inserting "FISCAL YEARS 2007 THROUGH 2009 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2010";

(ii) in subclause (I), by striking "or for a period in fiscal year 2008" and inserting ", 2008, 2009, or for a period in fiscal year 2010"; and

(iii) in subclause (II), by striking "or for a period in fiscal year 2008" and inserting ", 2008, 2009, or for a period in fiscal year 2010"; and

(3) in subparagraph (B)(i)—

(A) in the first sentence, by striking "fiscal year 2007" and inserting "each of fiscal years 2007 through 2009"; and

(B) by striking the second sentence and inserting the following: "Only with respect to fiscal year 2010 for the period ending on December 31, 2009, the DSH allotment for Hawaii for such portion of the fiscal year, notwithstanding the table set forth in paragraph (2), shall be $2,500,000.".

SEC. 203. PHARMACY REIMBURSEMENT UNDER MEDICAID.

(a) DELAY IN APPLICATION OF NEW PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS UNDER MEDICAID.—Notwithstanding paragraphs (4) and (5) of subsection (e) of section 1927 of the Social Security Act (42 U.S.C. 1396r–8) or part 447 of title 42, Code of Federal Regulations, as published on July 17, 2007 (72 Federal Register 39142)—

(1) the specific upper limit under section 447.332 of title 42, Code of Federal Regulations (as in effect on December 31, 2006) applicable to payments made by a State for multiple source drugs under a State Medicaid plan shall continue to apply through September 30, 2009, for purposes of the

availability of Federal financial participation for such payments; and

(2) the Secretary of Health and Human Services shall not, prior to October 1, 2009, finalize, implement, enforce, or otherwise take any action (through promulgation of regulation, issuance of regulatory guidance, use of Federal payment audit procedures, or other administrative action, policy, or practice, including a Medical Assistance Manual transmittal or letter to State Medicaid directors) to impose the specific upper limit established under section 447.514(b) of title 42, Code of Federal Regulations as published on July 17, 2007 (72 Federal Register 39142).

(b) TEMPORARY SUSPENSION OF UPDATED PUBLICLY AVAILABLE AMP DATA.—Notwithstanding clause (v) of section 1927(b)(3)(D) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(D)), the Secretary of Health and Human Services shall not, prior to October 1, 2009, make publicly available any AMP disclosed to the Secretary.

(c) DEFINITIONS.—In this subsection:

(1) The term "multiple source drug" has the meaning given that term in section 1927(k)(7)(A)(i) of the Social Security Act (42 U.S.C. 1396r–8(k)(7)(A)(i)).

(2) The term "AMP" has the meaning given "average manufacturer price" in section 1927(k)(1) of the Social Security Act (42 U.S.C. 1396r–8(k)(1)) and "AMP" in section 447.504(a) of title 42, Code of Federal Regulations as published on July 17, 2007 (72 Federal Register 39142).

SEC. 204. REVIEW OF ADMINISTRATIVE CLAIM DETERMINATIONS.

(a) IN GENERAL.—Section 1116 of the Social Security Act (42 U.S.C. 1316) is amended by adding at the end the following new subsection:

"(e)(1) Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under title XIX shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance, provided that such request is made during the 60-day period that begins on the date the State receives notice of the disallowance.

"(2)(A) A State may appeal a disallowance of a claim for federal financial participation under title XIX by the Secretary, or an unfavorable reconsideration of a disallowance, during the 60-day period that begins on the date the State receives notice of the disallowance or of the unfavorable reconsideration, in whole or in part, to the Depart-

mental Appeals Board, established in the Department of Health and Human Services (in this paragraph referred to as the 'Board'), by filing a notice of appeal with the Board.

"(B) The Board shall consider a State's appeal of a disallowance of such a claim (or of an unfavorable reconsideration of a disallowance) on the basis of such documentation as the State may submit and as the Board may require to support the final decision of the Board. In deciding whether to uphold a disallowance of such a claim or any portion thereof, the Board shall be bound by all applicable laws and regulations and shall conduct a thorough review of the issues, taking into account all relevant evidence. The Board's decision of an appeal under subparagraph (A) shall be the final decision of the Secretary and shall be subject to reconsideration by the Board only upon motion of either party filed during the 60-day period that begins on the date of the Board's decision or to judicial review in accordance with subparagraph (C).

"(C) A State may obtain judicial review of a decision of the Board by filing an action in any United States District Court located within the appealing State (or, if several States jointly appeal the disallowance of claims for Federal financial participation under section 1903, in any United States District Court that is located within any

State that is a party to the appeal) or the United States District Court for the District of Columbia. Such an action may only be filed—

"(i) if no motion for reconsideration was filed within the 60-day period specified in subparagraph (B), during such 60-day period; or

"(ii) if such a motion was filed within such period, during the 60-day period that begins on the date of the Board's decision on such motion.".

(b) CONFORMING AMENDMENT.—Section 1116(d) of such Act (42 U.S.C. 1316(d)) is amended by striking "or XIX,".

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act and apply to any disallowance of a claim for Federal financial participation under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) made on or after such date or during the 60-day period prior to such date.

SEC. 205. COUNTY MEDICAID HEALTH INSURING ORGANIZATIONS.

(a) IN GENERAL.—Section 9517(c)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1396b note), as added by section 4734 of the Omnibus Budget Reconciliation Act of 1990 and as amended by section 704 of the Medicare, Medicaid, and SCHIP

Benefits Improvement and Protection Act of 2000, is amended—

(1) in subparagraph (A), by inserting ", in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Ventura County, and in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Merced County" after "described in subparagraph (B)"; and

(2) in subparagraph (C), by striking "14 percent" and inserting "16 percent".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

TITLE K—MISCELLANEOUS

SEC. 301. EXTENSION OF TANF SUPPLEMENTAL GRANTS.

(a) EXTENSION THROUGH FISCAL YEAR 2009.—Section 7101(a) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 135) is amended by striking "fiscal year 2008" and inserting "fiscal year 2009".

(b) CONFORMING AMENDMENT.—Section 403(a)(3)(H)(ii) of the Social Security Act (42 U.S.C. 603(a)(3)(H)(ii)) is amended to read as follows:

"(ii) subparagraph (G) shall be applied as if 'fiscal year 2009' were substituted for 'fiscal year 2001'; and".

SEC. 302. 70 PERCENT FEDERAL MATCHING FOR FOSTER CARE AND ADOPTION ASSISTANCE FOR THE DISTRICT OF COLUMBIA.

(a) IN GENERAL.—Section 474(a) of the Social Security Act (42 U.S.C. 674(a)) is amended in each of paragraphs (1) and (2) by striking "(as defined in section 1905(b) of this Act)" and inserting "(which shall be as defined in section 1905(b), in the case of a State other than the District of Columbia, or 70 percent, in the case of the District of Columbia)".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on October 1, 2008, and shall apply to calendar quarters beginning on or after that date.

SEC. 303. EXTENSION OF SPECIAL DIABETES GRANT PROGRAMS.

(a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)) is amended by striking "2009" and inserting "2011".

(b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c)(2)(C) of the Public Health Service Act

(42 U.S.C. 254c–3(c)(2)(C)) is amended by striking "2009" and inserting "2011".

(c) REPORT ON GRANT PROGRAMS.—Section 4923(b) of the Balanced Budget Act of 1997 (42 U.S.C. 1254c–2 note), as amended by section 931(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554, and section 1(c) of Public Law 107–360, is amended—

(1) in paragraph (1), by striking "and" at the end;

(2) in paragraph (2)—

(A) by striking "a final report" and inserting "a second interim report"; and

(B) by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(3) a report on such evaluation not later than January 1, 2011.".

SEC. 304. IOM REPORTS ON BEST PRACTICES FOR CONDUCTING SYSTEMATIC REVIEWS OF CLINICAL EFFECTIVENESS RESEARCH AND FOR DEVELOPING CLINICAL PROTOCOLS.

(a) SYSTEMATIC REVIEWS OF CLINICAL EFFECTIVENESS RESEARCH.—

(1) STUDY.—Not later than 60 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine of the National Academies (in this section referred to as the "Institute") under which the Institute shall conduct a study to identify the methodological standards for conducting systematic reviews of clinical effectiveness research on health and health care in order to ensure that organizations conducting such reviews have information on methods that are objective, scientifically valid, and consistent.

(2) REPORT.—Not later than 18 months after the effective date of the contract under paragraph (1), the Institute, as part of such contract, shall submit to the Secretary of Health and Human Services and the appropriate committees of jurisdiction of Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and adminis-

trative action as the Institute determines appropriate.

(3) PARTICIPATION.—The contract under paragraph (1) shall require that stakeholders with expertise in conducting clinical effectiveness research participate on the panel responsible for conducting the study under paragraph (1) and preparing the report under paragraph (2).

(b) CLINICAL PROTOCOLS.—

(1) STUDY.—Not later than 60 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine of the National Academies (in this section referred to as the "Institute") under which the Institute shall conduct a study on the best methods used in developing clinical practice guidelines in order to ensure that organizations developing such guidelines have information on approaches that are objective, scientifically valid, and consistent.

(2) REPORT.—Not later than 18 months after the effective date of the contract under paragraph (1), the Institute, as part of such contract, shall submit to the Secretary of Health and Human Services and the appropriate committees of jurisdiction

of Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Institute determines appropriate.

(3) PARTICIPATION.—The contract under paragraph (1) shall require that stakeholders with expertise in making clinical recommendations participate on the panel responsible for conducting the study under paragraph (1) and preparing the report under paragraph (2).

(c) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for the period of fiscal years 2009 and 2010, $3,000,000 to carry out this section.

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